Supreme Court, U.S.
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No.

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1993

TIOGA PINES LIVING CENTER, INC., COMMUNICARE OF INDIANA, INC., D/B/A AMERICAN VILLAGE RETIREMENT COMMUNITY, BLOOMINGTON CONVALESCENT CENTER, INC., MEADOW HEIGHTS NURSING CENTER, INC., D/B/A LINCOLN HILLS OF NEW ALBANY, ET AL.,

*Petitioners,*

v.

INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, AND SUZANNE MAGNANT, in her capacity as ADMINISTRATOR OF INDIANA DEPARTMENT OF PUBLIC WELFARE,

*Respondents.*

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF INDIANA

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186 pp

## QUESTIONS PRESENTED

1. May a state's highest court, after discretionary abstention by a federal court, refuse to adjudicate dispositive federal claims brought against state agencies and officials where this Court in *Wilder* v. *Virginia Hospital Ass'n*, 496 U.S. 498 (1990), recognized an enforceable federal right and where the federal claims were presented to and decided in plaintiffs' favor by the state trial court?

2. Must a state's highest court accord the decisions of the federal courts the same degree of deference on questions of substantive federal law that a federal court would be obliged to accord to the decisions of the state courts on questions of state law, or may the state's highest court decide a federal claim pursuant to standards that conflict with settled principles of federal law that are recognized by this Court and used by the federal courts to decide claims under the same federal statute?

## PARTIES TO THE PROCEEDING

Parties to the proceeding below, other than those listed in the caption, are listed in Appendix E.

## RULE 29.1 LISTING

The list of corporate parents and non-wholly owned subsidiaries of parties who are corporations is set forth in Appendix F.

## TABLE OF CONTENTS


| | PAGE |
|---|---|
| Opinions Below | 1 |
| Jurisdiction | 2 |
| Statutory Provisions Involved | 2 |
| Statement of the Case | 2 |
| Reasons for Granting the Petition | 6 |
| I. Summary | 6 |
| II. The Indiana Supreme Court Did Not Decide Plaintiffs' Federal Procedural Claim | 8 |
| A. Plaintiffs' Claim That the State Defendants Did Not Make the Findings Required by Federal Law Was Properly Pled, Tried and Decided by the State Trial Court | 8 |
| B. Plaintiffs' Claim That the State Defendants Violated the Procedural Requirements of Federal Law Was Properly Presented to the Indiana Supreme Court | 11 |
| C. The Indiana Supreme Court Did Not Decide Plaintiffs' Federal Claim | 11 |
| D. A Writ Should Issue to Resolve the Conflict Between the Decision of the Indiana Supreme Court and the Decisions of This Court and Other Federal Courts and to Define the Responsibility of State Courts to Adjudicate Federal Claims | 13 |
| III. The Decision Below Conflicts with Decisions of This Court and of the Federal Courts of Appeal Because the Indiana Supreme Court Did Not Apply Federal Law to Decide Plaintiffs' Substantive Federal Claim | 16 |

PAGE

A. A Writ Should Issue to Delineate the Obligation of State Courts to Defer to Settled Law Applied by the Federal Courts When Adjudicating Federal Claims . . . . . 16

B. The Indiana Supreme Court Did Not Apply Settled Federal Law to Decide Petitioners' Substantive Federal Claims . . . . . 18

1. The Indiana Supreme Court Erroneously Accorded Deference to the State Defendants Regarding Substantive Compliance with the Boren Amendment Without First Determining Whether the State Defendants Complied with Procedural Requirements of the Boren Amendment . . . . . 18

2. The Indiana Supreme Court Decision Conflicts with Settled Federal Law by Requiring Plaintiffs to Carry a Burden of Proof That Conflicts with Federal Law and with Decisions of the Federal Courts . . . . . 20

3. The Indiana Supreme Court Determined that the State Defendants Complied with the Substantive Component of the Boren Amendment Without Considering the Statutory Requirement That Medicaid Payment Rates Be Adequate to Permit Nursing Homes to Deliver Quality Care . . . . 22

4. The Indiana Supreme Court Erroneously Evaluated the State Defendants' Substantive Compliance with the Boren Amendment by Focusing on the Adequacy of a Single Rate Component . . . . . 24

C. A Writ of Certiorari Should Issue to Resolve the Conflict Between the Decision of the Indiana Supreme Court and the Decisions of This Court and Other Federal Courts . . . . . 25

PAGE

IV. Conclusion . . . . . 27

APPENDICES

Appendix A . . . . . A-1
Appendix B . . . . . B-1
Appendix C . . . . . C-1
Appendix D . . . . . D-1
Appendix E . . . . . E-1
Appendix F . . . . . F-1
Appendix G . . . . . G-1
Appendix H . . . . . H-1
Appendix I . . . . . I-1

## TABLE OF AUTHORITIES

### CASES


| | PAGE |
|---|---|
| *Abbeville Gen. Hosp.* v. *Ramsey*, 3 F.3d 797 (5th Cir. 1993) | 12, 13, 19, 23 |
| *American Ry. Express* v. *Levee*, 263 U.S. 19 (1923) | 21 |
| *Amisub (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990) | 19 |
| *Anco, Inc.* v. *State Health & Human Servs. Fin. Comm'n*, 388 S.E.2d 780 (S.C. 1989) | 24 |
| *Arizona* v. *San Carlos Apache Tribe*, 463 U.S. 545 (1983) | 3 |
| *Arkansas Med. Soc'y* v. *Reynolds*, 6 F.3d 519 (8th Cir. 1993) | 12, 13, 23 |
| *Barr* v. *City of Columbia*, 378 U.S. 146 (1964) | 14 |
| *Bayh* v. *Sonnenburg*, 573 N.E.2d 398 (Ind. 1991), *cert. denied*, 112 S. Ct. 1170 (1992) | 7, 15, 18 |
| *Brown* v. *Western Ry.*, 338 U.S. 294 (1949) | 16, 17, 26 |
| *Charles Dowd Box Co.* v. *Courtney*, 368 U.S. 502 (1962) | 26 |
| *City of Pittsburgh* v. *Alco Parking Corp.*, 417 U.S. 369 (1974) | 16 |
| *Colorado Health Care Ass'n* v. *Colorado Dep't of Social Servs.*, 842 F.2d 1158 (10th Cir. 1988) | 12, 13, 24 |
| *Department of Health & Social Servs.* v. *Alaska State Hosp. & Nursing Home Ass'n*, 856 P.2d 755 (Alaska 1993) | 19 |
| *Dice* v. *Akron C&Y R.R.*, 342 U.S. 359 (1952) | 17, 26 |

| | PAGE |
|---|---|
| *Duquesne Light Co.* v. *Barasch*, 488 U.S. 299 (1989) | 24 |
| *English Coal Co.* v. *Durcholz*, 422 N.E.2d 302 (Ind. Ct. App. 1981) | 12 |
| *Eustis* v. *Bolles*, 150 U.S. 361 (1893) | 14 |
| *FERC* v. *Mississippi*, 456 U.S. 742 (1982) | 21 |
| *Felder* v. *Casey*, 487 U.S. 131 (1988) | 7, 14, 17, 21 |
| *Folden* v. *Washington State Dep't of Social & Health Servs.*, 744 F. Supp. 1507 (W. D. Wash. 1990), *aff'd*, 981 F.2d 1054 (9th Cir. 1992) | 23 |
| *Garrett* v. *Moore-McCormack Co.*, 317 U.S. 239 (1942) | 7, 14, 21, 26 |
| *Hathorn* v. *Lovorn*, 457 U.S. 255 (1982) | 14 |
| *Holmes* v. *Randolph*, 610 N.E.2d 839 (Ind. 1993) | 18 |
| *Howlett* v. *Rose*, 496 U.S. 356 (1990) | 6, 7, 14, 21 |
| *Hudson* v. *Louisiana*, 450 U.S. 40 (1981) | 16 |
| *Illinois Health Care Ass'n* v. *Bradley*, 983 F.2d 1460 (7th Cir. 1993) | 10, 12, 13, 14, 19, 23 |
| *Indiana Bureau of Motor Vehicles* v. *Zimmerman*, 476 N.E.2d 114 (Ind. 1985) | 18 |
| *Indiana Dep't of Pub. Welfare* v. *Payne*, 622 N.E.2d 461 (Ind. 1993) | 18 |
| *Indiana Dep't of State Revenue* v. *Felix*, 571 N.E.2d 287 (Ind. 1991), *cert. dismissed*, 112 S.Ct. 1073 (1992) | 18 |
| *Indiana State Bd. of Pub. Welfare* v. *Tioga Pines Living Ctr.*, 622 N.E.2d 935 (Ind. 1993) | 1, 18 |
| *In re Marriage of Snemis*, 575 N.E.2d 650 (Ind. Ct. App. 1991) | 12 |
| *Iowa-Des Moines Nat'l Bank* v. *Bennett*, 284 U.S. 239 (1931) | 8 |

| | PAGE |
|---|---|
| *Jackson* v. *Lykes Bros. S.S. Co.*, 386 U.S. 731 (1967) | 16 |
| *Kansas Health Care Ass'n* v. *Kansas Dep't of Social & Rehabilitation Servs.*, 822 F. Supp. 687 (D. Kan. 1993) | 19, 24 |
| *Lawrence* v. *State Tax Comm'n*, 286 U.S. 276 (1932) | 7, 16 |
| *Lumen Constr., Inc.* v. *Brant Constr. Co.*, 780 F.2d 691 (7th Cir. 1985) | 3 |
| *Maine* v. *Thiboutot*, 448 U.S. 1 (1980) | 26 |
| *Martin* v. *Hunter's Lessee*, 14 U.S. (1 Wheat.) 304 (1816) | 6 |
| *Martinez* v. *California*, 444 U.S. 277 (1980) | 21 |
| *Mississippi Hosp. Ass'n* v. *Heckler*, 701 F.2d 511 (5th Cir. 1983) | 12, 13, 19 |
| *Mondou* v. *New York, H.H. & H.R.R.*, 223 U.S. 1 (1912) | 26 |
| *Monessen S.W. Ry.* v. *Morgan*, 486 U.S. 330 (1988) | 21 |
| *NAACP* v. *Alabama ex rel. Patterson*, 357 U.S. 449 (1958) | 14 |
| *Nebraska Health Care Ass'n* v. *Dunning*, 778 F.2d 1291 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987) | 19, 23 |
| *Oklahoma Nursing Home Ass'n* v. *Demps*, 816 F. Supp. 688 (W.D. Okla. 1992) | 10, 23 |
| *Owen* v. *City of Independence*, 445 U.S. 622 (1980) | 21 |
| *Patsy* v. *Board of Regents*, 457 U.S. 496 (1982) | 7, 14 |
| *Pinnacle Nursing Home* v. *Axelrod*, 928 F.2d 1306 (2d Cir. 1991) | 10, 12, 13, 19 |
| *Rogers* v. *Alabama*, 192 U.S. 226 (1904) | 14 |

| | PAGE |
|---|---|
| *Temple Univ.* v. *White*, 941 F.2d 201 (3d Cir. 1991), *cert. denied*, 112 S. Ct. 873 (1992) | 12, 13, 19 |
| *Testa* v. *Katt*, 330 U.S. 386 (1947) | 16 |
| *United Farm Bureau Mut. Ins. Co.* v. *Blanton*, 457 N.E.2d 609 (Ind. Ct. App. 1983) | 12 |
| *Ward* v. *Board of County Comm'rs*, 253 U.S. 17 (1920) | 8 |
| *West Virginia Univ. Hosps., Inc.* v. *Casey*, 885 F.2d 11 (3d Cir. 1989), *cert. granted*, 494 U.S. 1003 (1990), *and later proceeding*, 898 F.2d 357 (3d Cir. 1990), *and cert. denied*, 496 U.S. 936 (1990), *and aff'd*, 499 U.S. 83 (1991) | 19 |
| *Wilder* v. *Virginia Hospital Ass'n*, 496 U.S. 498 (1990) | passim |
| *William E. Arnold Co.* v. *Carpenters Dist. Council*, 417 U.S. 12 (1974) | 16 |
| *Wilson* v. *Garcia*, 471 U.S. 261 (1985) | 16 |
| *Wisconsin Hosp. Ass'n* v. *Reivitz*, 733 F.2d 1226 (7th Cir. 1984) | 19 |


**STATUTES AND REGULATIONS**


| | |
|---|---|
| 28 U.S.C. § 1257(a) | 2 |
| 42 U.S.C. § 1396a(a)(13)(A) | passim |
| 42 U.S.C. § 1983 | 2, 9, 14 |
| 42 C.F.R. § 447 | 2 |
| 42 C.F.R. § 447.253(b) | 10 |


**MISCELLANEOUS**


| | |
|---|---|
| H.R. Rep. No. 391, 100th Cong., 1st Sess. 463 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-283 | 22 |

| | PAGE |
|---|---|
| Ind. Trial Rule 52(A) | 12 |
| Ind. Trial Rule 54(B) | 4 |
| Henry M. Hart, Jr., *The Relations Between Federal and State Law*, 54 Colum. L. Rev. 489 (1954) | 8 |
| Susan N. Herman, *Beyond Parity: Section 1983 and the State Courts*, 54 Brooklyn L. Rev. 1057 (1989) | 6 |
| Alfred Hill, *Substance and Procedure in State FELA Actions—The Converse of the Erie Problem?* 17 Ohio St. L.J. 384 (1956) | 17 |
| Burt Neuborne, *The Myth of Parity*, 90 Harv. L. Rev. 1105 (1977) | 7 |
| Burt Neuborne, *Toward Procedural Parity in Constitutional Litigation*, 22 Wm. & Mary L. Rev. 725 (1981) | 17 |
| Steven H. Steinglass, *The Emerging State Court § 1983 Action: A Procedural Review*, 38 U. Miami L. Rev. 381 (1984) | 6 |
| 1 Martin A. Schwartz & John E. Kirklin, Section 1983 Litigation: Claims, Defenses, and Fees (2d ed. 1991) | 6, 7 |

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INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, AND SUZANNE MAGNANT, in her capacity as ADMINISTRATOR OF INDIANA DEPARTMENT OF PUBLIC WELFARE,

*Respondents.*

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF INDIANA

Petitioners, Indiana nursing facilities who provide nursing home care and other services to elderly and disabled Medicaid recipients, seek a writ of certiorari to review the decision of the Supreme Court of Indiana in this case.

## OPINIONS BELOW

The Indiana Supreme Court's opinion dated October 29, 1993, reported at 622 N.E.2d 935 (Ind. 1993), is reproduced in its entirety as Appendix A. The orders of the Circuit Court of Hancock County, Indiana, which were appealed to the Indiana Supreme Court, are reproduced in their entirety as Appendix B (Judgment Entry dated September 18, 1991); Appendix C (Advisory Findings of Fact and Conclusions of Law dated September 19, 1991); and Appendix D (Partial Final Judgment Entry dated March 25, 1992).

## JURISDICTION

The judgment of the Indiana Supreme Court was issued on October 29, 1993. Appendix A. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

## STATUTORY PROVISIONS INVOLVED

Pertinent portions of the United States Constitution, the Civil Rights Act of 1871, 42 U.S.C. § 1983, and the Social Security Act, 42 U.S.C. § 1396a(a)(13)(A) and its implementing regulations, 42 C.F.R. § 447, are reproduced verbatim in Appendix G.

## STATEMENT OF THE CASE

On January 24, 1990, plaintiffs filed a complaint in state court alleging that the Indiana Medicaid reimbursement system for nursing homes was unlawful. At that time, the gravamen of plaintiffs' case in the state court was that the Indiana Medicaid program violated a number of state laws that are not at issue here. The state trial court certified the case as a class action.

The Indiana Health Care Association, Inc., and the Indiana Association of Homes for the Aging, Inc., two trade associations representing the interests of nearly all Medicaid-certified nursing homes in Indiana, subsequently filed a separate complaint in the United States District Court for the Southern District of Indiana, alleging that the Medicaid reimbursement system violated federal law in two ways: (1) the state had not made the findings and assurances required by federal law (the procedural claim under the Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A)); and (2) the state did not in fact pay reasonable and adequate Medicaid rates (the Boren Amendment substantive claim). The federal court plaintiffs also sought a preliminary injunction. The state defendants moved the federal court to abstain from exercising jurisdiction.

In October, 1990, because trial on the merits in the state court was scheduled to commence in late 1990 or early 1991, and because the federal court had not ruled on either the federal plaintiffs' motion for preliminary injunction or the state defendants' abstention motion, the federal plaintiffs moved to intervene in the state court class action.[1] The state court granted the motion to intervene, and the state complaint was amended to allege the same federal procedural and substantive violations that were the basis of the federal plaintiffs' complaint. Amended Complaint dated October 26, 1990, Appendix H, at H-10-H-12.

The federal district court found that the federal case paralleled the state case, and stayed the federal action pending completion of the state court proceedings. The district court stated that:

> [T]he plaintiffs' broad challenges under the Boren Amendment clearly do arise under federal statutes and regulations. . . . [W]e are not persuaded that plaintiffs' federal claims cannot be fairly adjudicated in the state courts. " 'State courts, as much as federal courts, have a solemn obligation to follow federal law.' We decline to presume that the Indiana courts, which have concurrent jurisdiction . . . , will not discharge this obligation faithfully." *Lumen Constr., Inc.* v. *Brant Constr. Co.*, 780 F.2d at 697 (quoting *Arizona* v. *San Carlos Apache Tribe*, 463 U.S. 545, 571, 103 S. Ct. 3201, 3216, 77 L.Ed.2d 837, 859 (1983)).

Abstention Order, Appendix I, at I-16.

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[1] Although the 151 intervening plaintiffs were nominally different from the federal plaintiffs, the intervenors acted on behalf of the two trade associations that had filed the federal complaint.

Following a three-week trial, the state trial court entered a general judgment in favor of the plaintiff nursing homes. Appendix B.[2] The state trial court also issued 60 pages of Advisory Findings of Facts and Conclusions of Law. Appendix C.

The state trial court concluded that the state defendants violated *both* the procedural and substantive components of the Boren Amendment. The trial court held that "there is no credible evidence that any official made a yearly finding" as required by federal law. Conclusion of Law 14, Appendix C, at C-38. *See also* Conclusion of Law 32 ("[t]he Court also concludes, as a matter of law, that . . . [the state defendants] did not make findings supported by a reasonable factual basis each year since April 1983"), Appendix C, at C-44; Findings of Fact 60, 92, 95, 96, 98-102, 104-106. Appendix C, at C-17, C-29-C-33. With respect to the substantive claims, the trial court held "as a matter of law, from all of the evidence, that the entire reimbursement system . . . results in Indiana facilities being paid rates below the standards required by" federal law. Conclusion of Law 31, Appendix C, at C-34. *See also* Conclusions of Law, 28-30, 33, Appendix C, at C-43-C-45.

The trial court awarded individual plaintiffs additional payments to remedy the violation of federal law. The judgment was estimated to require additional Medicaid payments of approximately $125 million for the period January 24, 1988, to March 31, 1991.[3]

The state defendants appealed the judgment to the Court of Appeals of Indiana (No. 30A01-9201-CV-008). The appeal was consolidated with another case which had found that the Medicaid program violated state law, *Indiana State Bd. of Pub.*

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[2] Later, the trial court entered a Partial Final Judgment pursuant to Ind. Trial Rule 54(B), Appendix D. The Partial Final Judgment Entry repeated much of the substance of the original Judgment Entry and also addressed certain other matters not at issue here.

[3] The estimate of damages was extrapolated from the state trial court's judgment entries, Appendices B and D.

*Welfare* v. *Community Care*. The consolidated appeal was transferred to the Indiana Supreme Court.

On October 29, 1993, the Indiana Supreme Court reversed the trial court and ordered that judgment be entered in favor of the state defendants. The Indiana Supreme Court did not mention plaintiffs' federal procedural claim, i.e., that the state defendants had not made the findings required by federal law. Appendix A. With respect to plaintiffs' substantive Boren Amendment claim, the court held that: (1) it must defer to agency expertise; (2) the plaintiffs had not carried their burden of proving that there was "no nexus" between rates and the costs of operating efficient and economical nursing facilities; and (3) a single element of the rate-setting scheme, known as the GNP/ipd maximum annual rate increase limitation, was not unreasonable. Appendix A, at A-8, A-21.

On December 17, 1993, the federal plaintiffs asked the district court to lift the stay entered in January, 1991, and to exercise jurisdiction over plaintiffs' unadjudicated federal claims. The motion has been fully briefed at this time, but not decided.

This lawsuit and the federal case began as challenges to the payment system originally adopted in 1983. Just before the trial concerning the 1983 system, the state defendants attempted to implement a new payment system, effective April 1, 1991. The plaintiffs amended the state court complaint to add federal claims challenging the 1991 system, and the trial court granted a preliminary injunction precluding the 1991 system from going into effect. Thus, the 1983 system remains in force. The state defendants appealed the preliminary injunction, and that appeal is pending in the Indiana Court of Appeals. The state defendants now have published rules designed to implement yet a third payment system, with an intended effective date of April 1, 1994.

## REASONS FOR GRANTING THE PETITION

### I. SUMMARY

A writ of certiorari should issue in this case to delineate the proper role and responsibility of state courts in cases alleging that state officials have violated federal law. In this case, the Indiana Supreme Court: (1) contrary to this Court's holding in *Wilder* v. *Virginia Hosp. Assn*, 496 U.S. 498 (1990), refused to decide one of plaintiffs' dispositive federal claims; and (2) although purporting to decide plaintiffs' second federal claim, did not apply settled federal law as set forth in federal statutes, in decisions of this Court and in decisions of numerous federal courts.

The Indiana Supreme Court's refusal to decide plaintiffs' federal claim and to apply federal law conflicts with bedrock principles of federalism embodied in the Supremacy Clause of the Constitution and in decisions of this Court as venerable as *Martin* v. *Hunter's Lessee*, 14 U.S. (1 Wheat.) 304, 340 (1816), and as recent as *Howlett* v. *Rose*, 496 U.S. 356 (1990). The increasing role that Congress and this Court have assigned to state courts to arbitrate and enforce federal rights against state defendants requires a clear statement from this Court confirming the state courts' obligation to decide federal claims and to apply federal law.[4]

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[4] *See, e.g.*, 1 Martin A. Schwartz & John E. Kirklin, Section 1983 Litigation: Claims, Defenses, and Fees 49-51 (2d ed. 1991); Steven H. Steinglass, *The Emerging State Court § 1983 Action: A Procedural Review*, 38 U. Miami L. Rev. 381, 432-39 (1984); Susan N. Herman, *Beyond Parity: Section 1983 and the State Courts*, 54 Brooklyn L. Rev. 1057, 1111 (1989).

In this case the conflict between the obligations imposed by federal law and competing local interests and prejudices is in sharp focus. Numerous commentators have noted that, in cases such as this one, the magnitude of the remedy necessary to enforce federal law, including the Boren Amendment, makes state courts reluctant to uphold a judgment against state defendants.[5] "State courts hearing section 1983 actions . . . are not disinterested. The behavior of state officials of that state is at issue, so state court judges may be perceived as having a greater stake in the outcome of the case."[6]

Whether this Court would agree or disagree with the ultimate disposition of plaintiffs' federal claims by the state court is irrelevant for purposes of this petition. The pertinent point is that:

> [C]onstitutional rights are denied as well *by the refusal of the state court to decide the question,* as by an erroneous decision of it . . . for in either case the inequality complained of is left undisturbed by the state court whose jurisdiction to remove it was rightly invoked.

*Lawrence* v. *State Tax Comm'n*, 286 U.S. 276, 282 (1932) (emphasis added) (citations omitted); *see also Wilder*, 496 U.S. at 520 n.18. Further, a litigant's ability to vindicate federal rights should not depend on whether the federal claims are litigated in the state courts or in the federal courts. *See, e.g., Howlett*, 496 U.S. at 375; "([t]he elements of, and the defenses to, a federal cause of action are defined by federal law."); *Felder* v. *Casey*, 487 U.S. 131, 151 (1988); *Garrett* v. *Moore-McCormack Co.*, 317 U.S. 239, 245-49 (1942).

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[5] *See, e.g., Bayh* v. *Sonnenburg*, 573 N.E. 2d 398, 427 (Ind. 1991) (Dickson, J., dissenting), *cert. denied*, 112 S. Ct. 1170 (1992).

[6] Schwartz & Kirklin, *supra* note 4 at 49-50. *See also Patsy* v. *Board of Regents*, 457 U.S. 496, 505-07 (1982); Burt Neuborne, *The Myth of Parity*, 90 Harv. L. Rev. 1105, 1117 (1977).

The Indiana Supreme Court decision directly conflicts with decisions of this Court, and with those of numerous federal courts of appeals. By completely ignoring and failing to decide plaintiffs' federal procedural claim, the Indiana Supreme Court deprived plaintiffs of the rights that were explicitly recognized by this Court in *Wilder* and of their constitutional right to seek redress of grievances. The Indiana Supreme Court also deprived plaintiffs of rights conferred by federal law by deciding plaintiffs' substantive federal claims pursuant to decisional standards that conflict with the standards used by the federal courts to decide Boren Amendment claims.

Although the Supremacy Clause arguably requires considerably more, at the very least, state courts should accord the same deference to decisions of the federal courts on questions of federal law as the federal courts are obliged to accord to the decisions of the state courts on questions of state law.[7] A rule or practice that permits state courts to deny federal rights by refusing to adjudicate properly-presented federal claims, or by applying decisional standards different than the federal courts, will have a pernicious impact on efforts to enforce in state court the rights conferred by the Constitution and by numerous federal statutes.

## II. THE INDIANA SUPREME COURT DID NOT DECIDE PLAINTIFFS' FEDERAL PROCEDURAL CLAIM.

### A. Plaintiffs' Claim That the State Defendants Did Not Make the Findings Required by Federal Law Was Properly Pled, Tried and Decided by the State Trial Court.

In *Wilder*, 496 U.S. at 524, this Court held that "[t]he Boren Amendment to the [Medicaid] Act creates a right, enforceable in

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[7] *See* Henry M. Hart, Jr., *The Relations Between Federal and State Law*, 54 Colum. L. Rev. 489, 507 (1954) ("[t]he supremacy clause, of course, makes plain that if a state court undertakes to adjudicate a [federal] controversy it must do so in accordance with whatever federal law is applicable") (citing *Iowa-Des Moines Nat'l Bank* v. *Bennett*, 284 U.S. 239 (1931) and *Ward* v. *Board of County Comm'rs*, 253 U.S. 17 (1920)).

a private cause of action pursuant to § 1983, to have the State adopt rates that it finds are reasonable and adequate rates to meet the costs of an efficient and economical health care provider." This Court also held that "[i]f a State errs in finding that its rates are reasonable and adequate . . . , then a provider is entitled to have the court invalidate the current state plan and order the State to promulgate a new plan that complies with the Act." *Id.* at 520 n.18.

Plaintiffs, following the principles enunciated in *Wilder*, pled and tried federal procedural claims in the state trial court. The state trial court found that "[t]he amended complaint also included a federal procedural claim under 42 U.S.C. § 1983 that Defendants failed to make certain 'findings' that the Medicaid reimbursement rates complied with the Boren Amendment." Finding of Fact 13, Appendix C, at C-5. See also, Abstention Order, Appendix I, at I-9.

The state trial court determined that the state defendants did not make the findings required by the Boren Amendment.[8] The trial court found that:

> —The state defendants never identified or compared payment rates to the "objective benchmark" of an efficiently and economically operated nursing home or to the costs necessarily incurred by such a nursing home to deliver quality care as contemplated by the federal statute and by this Court in *Wilder. See* Findings of Fact 98, 99, 105, Appendix C, at C-29-C-33;[9]

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[8] Findings of Fact 30, 60, 61, 85, 92-106, Appendix C, at C-10, C-17, C-26-C-27, C-29-C-33. Conclusions of Law 14, 28, 29, 32, Appendix C, at C-38, C-43-C-44.

[9] *Compare, e.g., Wilder,* 496 U.S. at 519.

—There were no documents in existence or identified by the state defendants that contain the findings or supporting data. *See* Findings of Fact 100, 101, 102, Appendix C, at C-29-C-33;[10]

—The state defendants performed no principled or objective studies of the reasonableness or adequacy of the rate and never analyzed or even thought about the relationship between payment rates and the nursing homes' ability to deliver quality care in conformity with health, safety and quality standards. *See* Findings of Fact 33, 85, 106, Appendix C, at C-10, C-26-C-37, C-33;[11]

—The state officials responsible for the findings were not aware of the pertinent factors to be considered or the facts related to such factors. *See* Findings of Fact 95, 96, 98, 99, Appendix C, at C-29-C-33;

—The testimony of the state officials who were responsible for making the findings was not credible because, among other things, the documents supposedly used in the findings process were actually prepared years after the rate years at issue, and after this lawsuit was filed. *See* Findings of Fact 60, 61, 104, Appendix C, at C-17, C-32.[12]

Based on these factual determinations, the trial court concluded that the state defendants "did not make annual findings that the payment rates complied with federal law. Indeed, there

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[10] *Compare, e.g., Illinois Health Care Ass'n v. Bradley,* 983 F.2d 1460, 1465 (7th Cir. 1993).

[11] *Compare, e.g., Wilder,* 496 U.S. at 520 n.17 ("[W]hen determining methods of calculating rates that are reasonably related to the costs of an efficient hospital, a State must consider: . . . (2) the statutory requirements for adequate care in a nursing home . . . ."); *see also Pinnacle Nursing Home v. Alexrod*, 928 F.2d 1306, 1315-16 (2d Cir. 1991).

[12] *Compare, e.g., Pinnacle Nursing Home,* 928 F.2d at 1315-16 (annual findings must be made before rate is implemented), and *Oklahoma Nursing Home Ass'n v. Demps,* 816 F. Supp. 688, 701 (W.D. Okla. 1992) (state cannot make "nunc pro tunc findings in the middle of the fiscal year"); *see* 42 C.F.R. § 447.253(b).

is no credible evidence that any [state] official made a yearly finding. [The state defendants] did not undertake an annual objective and principled analysis of the readily available information. Such information plainly showed that nursing home rates were not reasonable or adequate to permit facilities to meet quality and safety standards." Conclusion of Law 14, Appendix C, at C-38. *See also* Conclusions of Law 28, 29 and 32, Appendix C, at C-43-C-44.

### B. Plaintiffs' Claim That the State Defendants Violated the Procedural Requirements of Federal Law Was Properly Presented to the Indiana Supreme Court.

The state defendants' opening brief in the Indiana Supreme Court identifies as one of the principal issues presented for review the question of "[w]hether the trial court erred in finding that the State had failed to make annual 'findings' about adequacy of rates, pursuant to a federal Medicaid regulation." *See* Brief of Appellants, Appendix J, at J-3. *See* also Brief of Appellees and Cross-Appellants, Appendix J, at J-6. The briefs of all parties argued the appropriateness of the trial court's ruling on the federal findings issue. *See* Brief of Appellants at 65-71; Brief of Appellees at 42-44; Brief of Appellees and Cross-Appellants at 31-39; Reply Brief of Appellants at 35-42.

### C. The Indiana Supreme Court Did Not Decide Plaintiffs' Federal Claim.

The Indiana Supreme Court opinion never describes plaintiffs' procedural claim, never discusses the findings requirement imposed by federal law, never refers to any of the trial court's findings of fact or conclusions of law concerning plaintiffs' federal procedural claim, never discusses the standards applied in federal cases deciding similar federal claims, and never even uses the word "findings."[13] In *Wilder* and in other appellate cases

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[13] The Indiana Supreme Court's failure to adjudicate plaintiffs' federal claim is even more surprising because, in addition to federal law, state law obligated the court to consider and to decide plaintiffs' federal claims. The

*(footnote continues)*

where plaintiffs have alleged that a state has violated the findings obligations imposed by federal law, the opinions spend pages setting forth the applicable legal standard, discussing the precedents and analyzing the evidence produced on the question. *See, e.g., Wilder* 496 U.S. at 505-19; *Abbeville Gen. Hosp.* v. *Ramsey*, 3 F.3d 797, 801-04 (5th Cir. 1993); *Bradley*, 983 F.2d at 1464-65; *Arkansas Medical Soc'y, Inc.* v. *Reynolds*, 6 F.3d 519, 529-31 (8th Cir. 1993); *Pinnacle Nursing Home*, 928 F.2d at 1313-16; *Temple Univ.* v. *White*, 941 F.2d 201, 207-10 (3d Cir. 1991), *cert. denied*, 112 S. Ct. 873 (1992); *Colorado Health Care Ass'n* v. *Colorado Dep't of Social Servs.*, 842 F.2d 1158, 1165-66 (10th Cir. 1988); *Mississippi Hosp. Ass'n* v. *Heckler*, 701 F.2d 511, 516-17 (5th Cir. 1983).

In contrast, the state supreme court here mischaracterized the "illegality upon which the [trial court's] judgment is based [as] clearly substantive." Appendix A, at A-15.[14] This ruling cannot be reconciled with the trial court's findings and conclusions, with the briefs in the state supreme court, or with this Court's holding in *Wilder* that the Boren Amendment confers an

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*(footnote continued)*

trial court's judgment entries are general judgments. Ind. T.R. 52(A). Indiana law requires a reviewing court to affirm a general judgment if there is any legal basis supporting the judgment. *In re Marriage of Snemis*, 575 N.E.2d 650, 652 (Ind. Ct. App. 1991); *see United Farm Bureau Mut. Ins. Co. v. Blanton*, 457 N.E.2d 609 (Ind. Ct. App. 1983); *English Coal Co. v. Durcholz*, 422 N.E.2d 302 (Ind. Ct. App. 1981). Thus, the Indiana Supreme Court's failure to decide plaintiffs' federal claims is impossible to reconcile with the court's duty under state law, as well as federal law, to adjudicate these claims.

[14] In addition to its procedural determinations that no findings were made as to the payment system as a whole, the trial court in fact found that no findings had been made with respect to the single rate component addressed by the state supreme court (or, indeed, with respect to any component of the plan). Finding of Fact 30, Appendix C, at C-10. ("No analysis of how this index would impact on the remainder of the reimbursement system or the provision of quality services to the citizens of Indiana was ever done by any state agency, its staff or retained independent contractors prior to the installation of the index within the system. It was solely a budget driven, cost containment device.")

enforceable procedural right on health care providers that requires a state Medicaid agency to make the findings required by federal law.

This petition is not predicated on the assertion that the Indiana Supreme Court wrongly decided the federal findings issue. This petition is brought because the Indiana Supreme Court never decided—correctly or otherwise—whether the state violated the federal findings requirement despite its clear obligation under federal and state law to decide the question.

### D. A Writ Should Issue to Resolve the Conflict Between the Decision of the Indiana Supreme Court and the Decisions of This Court and Other Federal Courts and to Define the Responsibility of State Courts to Adjudicate Federal Claims.

The Indiana Supreme Court's failure to decide whether the state defendants violated the federal findings requirement is not a technicality. All federal courts—including this Court—that have considered the consequences of a state's failure to make the findings required by federal law have held that proof of a violation of the findings requirement entitles the plaintiff to relief. *See Wilder*, 496 U.S. at 520 n.18; *Abbeville Gen. Hosp.*, 3 F.3d at 801-04; *Bradley*, 983 F.2d at 1464-65; *Arkansas Medical Soc'y*, 6 F.3d at 529-31; *Pinnacle Nursing Home*, 928 F.2d at 1313-16; *Temple Univ.*, 941 F.2d at 207-10; *Colorado Health Care Ass'n*, 842 F.2d at 1165-66; and *Mississippi Hosp. Ass'n*, 701 F.2d at 516-17.

The conflict between the decision at issue here and the rulings of the federal courts is evident when the Indiana Supreme Court decision is compared to a recent decision of the Seventh Circuit Court of Appeals applying *Wilder*. In *Illinois Health Care Ass'n.* v. *Bradley*, a case that arose in the same time frame and legal context as this case, the Seventh Circuit declared that Illinois violated the federal findings requirement. 983 F.2d 1460. As a result, the Seventh Circuit held that the state Medicaid Plan was invalid. *Id.*

The analysis on which the Seventh Circuit based its ruling in *Bradley* is less comprehensive but otherwise indistinguishable from the findings and conclusions made by the trial court in this case. For example, in this case the state trial court, like the federal court in *Bradley*, found that the absence of studies, analysis and supporting documentation demonstrated that the state defendants did not make the findings mandated by federal law. *Compare* Findings of Fact 33, 60-61, 85, 95, 106 (Appendix C, at C-10-C-11, C-17, C-29-C-30, C-33) *with Bradley*, 983 F.2d at 1465-67. In fact, when the state trial court's findings are compared to the Seventh Circuit's decision in *Bradley*, the conclusion is inescapable: this case would have been resolved long ago in plaintiffs' favor had litigation proceeded in the federal courts.

The state court's refusal to decide plaintiffs' federal claim conflicts directly with numerous long-standing decisions of this Court requiring that state courts must enforce federal law as written by Congress. *Howlett*, 496 U.S. at 367-69; *Hathorn* v. *Lovorn*, 457 U.S. 255, 263 (1982); *Barr* v. *City of Columbia*, 378 U.S. 146, 149 (1964); *NAACP* v. *Alabama ex rel. Patterson*, 357 U.S. 449, 455 (1958); *Rogers* v. *Alabama*, 192 U.S. 226, 230-31 (1904); *Eustis* v. *Bolles*, 150 U.S. 361 (1893). The state court's failure to decide the federal procedural claim here is especially egregious because the state court was asked to enforce plaintiffs' federal rights against state defendants.

As Congress recognized when it adopted 42 U.S.C. § 1983, and as this Court often has stated, state courts historically have been reluctant or unwilling to enforce federal law when, as here, the consequence of an adverse judgment is a substantial burden on the state that is inconsistent with the state's parochial interests. *See, e.g., Felder*, 487 U.S. at 147; *Patsy*, 457 U.S. at 505-06; *Garrett*, 317 U.S. at 245. Similar criticism was directed at the Indiana Supreme Court in a recent case:

> I share my colleagues' apparent regard for the magnitude of the award and its fiscal impact upon the state treasury. However, such award also reflects the magnitude of the aggregate loss resulting from the [state

> defendants alleged violation of federal law]. Concern for the former cannot justify disregard of the latter.

*Bayh*, 573 N.E. 2d at 427 (Dickson, J., dissenting).

Nonetheless, as in this case, the state courts in many instances may be the only forum that can afford relief for violations of federal law by state defendants. In cases such as this, where most or all of the federal law violations occurred in the past, there is a possibility, if the state court is permitted to ignore plaintiffs' federal claim, that the Eleventh Amendment may preclude these and other similarly situated plaintiffs from obtaining any adjudication of their claims that federal law has been violated.[15] If the federal courts are barred from enforcing federal rights and the state courts are unwilling to do so, federal law is made subservient to state and local considerations and the rights conferred by federal law are rendered illusory. In this case, for example, it would be a gross miscarriage of justice if the federal court's decision to abstain, in the express belief that the state courts would fulfill their "solemn obligation to follow federal law" (Abstention Order, Appendix I, at I-16, citations omitted), caused the plaintiffs to lose those claims and never have them decided.

The Indiana Supreme Court decision rests on the unacceptable premise that state courts may pick and choose the federal claims that they will adjudicate. As in the past, this Court should not hesitate to grant certiorari to assure that the basic principles guaranteeing the supremacy of federal law are not eroded by an

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[15] At this time the state defendants are actively seeking to replace the 1983 reimbursement system at issue here with a new, far more restrictive payment methodology. Thus, extinguishment of plaintiffs' rights to have their federal claims regarding the current payment system decided in some forum is a real and imminent possibility because the Eleventh Amendment may preclude jurisdiction over the claim in the only remaining forum—other than this Court—conceivably open to plaintiffs, namely the federal district court.

unwillingness of state courts to adjudicate federal claims.[16] This Court should make clear that even where, as here, enforcement of a federal right requires an award of substantial and costly relief against state defendants, the state court nonetheless cannot "refuse to enforce the right arising from the law of the United States because of conceptions of impolicy or want of wisdom on the part of Congress in having called into play its lawful powers." *Testa*, 330 U.S. at 393.

## III. THE DECISION BELOW CONFLICTS WITH DECISIONS OF THIS COURT AND OF THE FEDERAL COURTS OF APPEAL BECAUSE THE INDIANA SUPREME COURT DID NOT APPLY FEDERAL LAW TO DECIDE PLAINTIFFS' SUBSTANTIVE FEDERAL CLAIM.

### A. A Writ Should Issue to Delineate the Obligation of State Courts to Defer to Settled Law Applied by the Federal Courts When Adjudicating Federal Claims.

Despite the trial court's comprehensive analysis of the federal substantive payment standards and the evidence addressing these standards, the Indiana Supreme Court resolved plaintiffs' substantive federal claims here pursuant to different principles, and with a different outcome, than would have occurred if the federal courts had exercised jurisdiction over such claims instead of abstaining. Granting the writ of certiorari will allow this Court to definitively state that the decisional rules applied in federal question litigation against state defendants, and the outcome of such litigation, may not be dependent upon whether federal claims are litigated in the state courts or in the federal courts.

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[16] *See, e.g., Mondou v. New York, H.H. & H.R.R.*, 223 U.S. 1, 57 (1912); *Testa v. Katt*, 330 U.S. 386, 390 (1947); *Lawrence*, 286 U.S. at 282. See also *Wilson* v. *Garcia*, 471 U.S. 261, 265-66 (1985); *Hudson* v. *Louisiana*, 450 U.S. 40, 42 (1981); *William E. Arnold Co.* v. *Carpenters Dist. Council*, 417 U.S. 12, 14 (1974); *City of Pittsburgh* v. *Alco Parking Corp.*, 417 U.S. 369, 371-72 (1974); *Jackson* v. *Lykes Bros. S.S. Co.*, 386 U.S. 731, 732 (1967); *Brown* v. *Western Ry.*, 338 U.S. 294, 294-95 (1950).

The Constitution requires that state courts enforce federal law as enacted by Congress and does not permit state courts to subject federal rights to additional terms and conditions or to the state's laws, policies or objectives. For example, state courts may not defeat federal rights by interposing local forms of practice, standards or rules of decision, if those practices or rules "will frequently and predictably produce different outcomes in federal civil rights litigation based solely on whether that litigation takes place in state or federal court. States may not apply such an outcome-determinative law when entertaining substantive federal rights in their courts." *Felder*, 487 U.S. at 141; see also, *Brown*, 338 U.S. at 296, 298-99. "[I]f the States afford courts for enforcing the Federal Act, they must enforce the substance of the right given by Congress. They cannot depreciate the legislative currency issued by Congress -- either expressly or by local methods of enforcement that accomplish the same result." *Dice* v. *Akron C&Y R.R.*, 342 U.S. 359, 369 (1952) (Frankfurter, J., dissenting from remand but concurring in the judgment).

Issuance of a writ is particularly appropriate in this case because, as this Court has recognized, the dispositive legal principles that the Indiana Supreme Court ignored were largely settled in the federal Courts of Appeals even before the 1990 *Wilder* decision. *Wilder*, 496 U.S. at 520 n.18. At the very least, state courts adjudicating federal claims should be obliged to accord the same deference to federal court rulings on questions of federal law as federal courts accord state courts when adjudicating state claims. *See, e.g.*, Burt Neuborne, *Toward Procedural Parity in Constitutional Litigation*, 22 Wm. & Mary L. Rev. 725, 766-77 (1981); Alfred Hill, *Substance and Procedure in State FELA Actions -- The Converse of the Erie Problem*? 17 Ohio St. L.J. 384 (1956).

A writ of certiorari also should issue because this is not an isolated or inadvertent instance in which the Indiana Supreme Court refused to apply settled federal law. In this case, the Indiana Supreme Court failed to adjudicate plaintiffs' substantive claim pursuant to the principles set forth in federal law and

in the decisions of the federal courts in at least four critical respects. Further, only nine days before the decision in this case was issued, the Indiana Supreme Court reaffirmed that as a matter of long-standing policy it does not have to apply the principles or interpretations of federal law followed by the federal appellate courts. *See Indiana Dep't of Pub. Welfare* v. *Payne*, 622 N.E.2d 461, 468 (Ind. 1993).[17]

### B. The Indiana Supreme Court Did Not Apply Settled Federal Law to Decide Petitioners' Substantive Federal Claim.

#### 1. The Indiana Supreme Court Erroneously Accorded Deference to the State Defendants Regarding Substantive Compliance with the Boren Amendment Without First Determining Whether the State Defendants Complied with Procedural Requirements of the Boren Amendment.

More than three years before the decision in this case, this Court in *Wilder* identified the appropriate federal standard of review:

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[17] A review of section 1983 actions adjudicated by the Indiana Supreme Court over the past eight years suggests that the court has consistently reversed trial court decisions in favor of section 1983 plaintiffs when the State is a defendant. Excluding criminal cases, the State of Indiana was a defendant in five cases. *See Indiana State Bd. of Pub. Welfare* v. *Tioga Pines Living Ctr. Inc.*, 622 N.E.2d 935 (Ind. 1993); *Holmes* v. *Randolph*, 610 N.E.2d 839 (Ind. 1993); *Bayh*, 573 N.E.2d 398; *Indiana Dep't of State Revenue* v. *Felix*, 571 N.E.2d 287 (Ind. 1991), *cert. dismissed*, 112 S. Ct. 1073 (1992); *Indiana Bureau of Motor Vehicles* v. *Zimmerman*, 476 N.E.2d 114 (Ind. 1985). In each case, the trial court ruled against the State but the supreme court reversed, ruling in favor of the State. In four of these cases *Tioga Pines, Holmes, Bayh and Felix*, the plaintiff was a certified class. In three of these cases, *Tioga Pines, Bayh and Felix*, the trial court judgment imposed a substantial monetary obligation on the State. It is apparent that in all cases but *Tioga Pines*, the court addressed in some detail the plaintiffs' federal claims. By comparison, the cursory treatment of plaintiffs' federal claims by the court in *Tioga Pines* is striking.

> We note that the Courts of Appeals generally agree that when the State has complied with the procedural requirements imposed by the amendment and regulations, a federal court employs a deferential standard of review to evaluate whether the rates comply with the substantive requirements of the amendment.

496 U.S. at 520 n.18. Thus, as the Fifth Circuit recently explained:

> [A] presumption of regularity and deferential standard attaches to [the Medicaid agency's] exercise of discretion in setting reimbursement rates, but only after a reviewing court determines that [the agency] made *bona fide* findings.
>
> The first question then is whether [the agency] made findings in compliance with the Boren Amendment procedural requirements. If yes, then and only then will we need to inquire into the substantive adequacy and reasonableness of these reimbursement rates using the arbitrary and capricious standard of review.

*Abbeville Gen. Hosp.*, 3 F. 3d at 804. *See also Temple Univ.*, 941 F.2d at 209-10; *Amisub (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789, 795-801 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990); *West Virginia Univ. Hosps., Inc.* v. *Casey*, 885 F.2d 11, 23-24 (3d Cir. 1989), *cert. granted*, 494 U.S. 1003 (1990), *and later proceeding*, 898 F.2d 357 (3d Cir. 1990), *and cert. denied*, 496 U.S. 936 (1990), *and aff'd*, 499 U.S. 83 (1991); *Nebraska Health Care Ass'n* v. *Dunning*, 778 F.2d 1291, 1294 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987); *Wisconsin Hosp. Ass'n* v. *Reivitz*, 733 F.2d 1226, 1232-33 (7th Cir. 1984); *Mississippi Hosp. Ass'n*, 701 F.2d at 516; *Kansas Health Care Ass'n* v. *Kansas Dep't of Social & Rehabilitation Servs.*, 822 F. Supp. 687, 690 (D. Kan. 1993); *Department of Health & Social Servs.* v. *Alaska State Hosp. & Nursing Home Ass'n*, 856 P.2d 755 (Alaska 1993); *cf. Pinnacle*, 928 F.2d at 1313 and *Bradley*, 983 F.2d at 1463 (courts advert to arbitrary and capricious standards of review where

some findings exist but find Medicaid plans invalid solely due to inadequacy of findings).

The state trial court followed federal law and "first determine[d] whether the plan was prepared procedurally and substantively in compliance with the Medicaid Act and its implementing regulations" and properly refused to accord deference because the annual findings required by federal law were not made. Findings of Fact 100-02, Conclusion of Law 11, Appendix C, at C-37. The Indiana Supreme Court, however, applied a deferential review standard *without ever deciding whether the state had made any findings* as required by the Boren Amendment, stating that "[t]he agency's action will not be overturned unless it is purely arbitrary or an error of law has been made." Appendix A, at A-7. By ignoring the federal review standard in favor of a deferential standard, the Indiana Supreme Court denied petitioners the right to have their federal claims determined pursuant to federal law.

**2. The Indiana Supreme Court Decision Conflicts with Settled Federal Law by Requiring Plaintiffs to Carry a Burden of Proof That Conflicts with Federal Law and with Decisions of the Federal Courts.**

This Court has long held that state courts adjudicating federal claims may not require a plaintiff to carry a burden of proof different from the burden imposed by federal law:

> If by its practice the state court were permitted substantially to alter the rights of either litigant, as those rights were established in federal law, the remedy afforded by the State would not enforce, but would actually deny, federal rights which Congress, by providing alternative remedies, intended to make not less but more secure. The constant objective of legislation and jurisprudence is to assure litigants full protection for all substantive rights intended to be afforded them by the jurisdiction in which the right itself originates . . . .

> The right of the petitioner to be free from the burden of proof imposed by the Pennsylvania local rule inhered in his cause of action . . . . [I]t was a part of the very substance of his claim and cannot be considered a mere incident of a form of procedure.

*Garrett*, 317 U.S. at 245-49; *see also Howlett*, 496 U.S. at 375 ("[t]he elements of, and the defenses to, a federal cause of action are defined by federal law"); *Felder*, 487 U.S. at 152 (state courts are prohibited from "demanding compliance with outcome-determinative rules that are inapplicable when such [federal] claims are brought in federal court . . ."); *Monessen S.W. Ry.* v. *Morgan*, 486 U.S. 330, 335-36 (1988); *FERC* v. *Mississippi*, 456 U.S. 742, 766 (1982); *Martinez* v. *California*, 444 U.S. 277, 283-84 (1980); *Owen* v. *City of Independence*, 445 U.S. 622, 647 n.30 (1980); *American Ry. Express* v. *Levee*, 263 U.S. 19, 21 (1923).

Under federal law, a plaintiff proves a substantive violation of the Boren Amendment if Medicaid rates are shown to be unreasonable or inadequate to achieve specific quality of care and other goals set forth in federal statutes and regulations. *Wilder*, 496 U.S. at 519 n.17; 42 U.S.C. § 1396a(a)(13)(A). In contrast, the state supreme court held that "the burden was upon the plaintiffs in the trial court to establish that there was no nexus between the costs of operating efficient and economical nursing facilities and the rates under the State's plan." Appendix A, at A-8. But the mere existence of any "nexus," or connection, between rates and costs does not save an inadequate rate. A "nexus" between costs and rates would exist if rates were set at one-tenth of the reasonable cost of providing adequate care. If all that were required were a "nexus" between costs and rates, as the Indiana Supreme Court would have it, such a system would be legal. Under the plain language of the Boren Amendment, however, such a system would obviously be illegal.

Whether a rate is reasonable and adequate under federal law is contingent on whether payment is "reasonable and adequate to meet" specified costs, and whether a rate allows providers to achieve the quality of care and other goals established by

federal and state law. 42 U.S.C. § 1396a(a)(13)(A). Recent amendments to the Boren Amendment confirm one of the pre-eminent objectives Congress sought to achieve was to assure that reimbursement rates would be sufficient to assure that nursing home residents received quality care so that they would "attain or maintain the highest practicable physical, mental and psychosocial wellbeing." 42 U.S.C. § 1396a(a)(13)(A) (Supp. 1991). *See also* H.R. Rep. No. 391, 100th Cong., 1st Sess. 463 (1987), *reprinted in* 1987 U.S.C.C.A.N., 2313-283 through 2313-284.

The burden of proof the Indiana Supreme Court imposed ignores *both* the reasonableness test and the quality of care, access, and other standards established by federal law. Indeed, the Indiana Supreme Court's formulation of the burden of proof rewrites federal law and redefines the elements of plaintiffs' federal cause of action.

The burden of proof imposed on the plaintiffs by the Indiana Supreme Court not only contradicts the language of the Boren Amendment (and the many federal cases interpreting it) but requires the plaintiffs to do the impossible: to prove a negative proposition, i.e., that there is no "nexus" between costs of operation and Indiana's payment rates. By requiring proof of the absence of a fact, the state court has fashioned an outcome-determinative requirement which no litigant ever could meet. Petitioners have the right to have their federal claims adjudicated under the standards imposed by federal law, including the correct federal burden of proof.

### 3. The Indiana Supreme Court Determined That the State Defendants Complied with the Substantive Component of the Boren Amendment Without Considering the Statutory Requirement That Medicaid Payment Rates Be Adequate to Permit Nursing Homes to Deliver Quality Care.

Federal law specifies that Medicaid reimbursement rates are reasonable and adequate only if nursing homes are able "to

provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards." 42 U.S.C. § 1396a(a)(13)(A). The state trial court described this action as follows:

> This case involves the question of the relationship between financial issues and the adequacy of the quality of resident care being provided to the citizens of Indiana in nursing homes. The evidence demonstrates that reimbursement rates are not reasonable and adequate to cover the costs facilities must incur to provide the care required to comply with prevailing quality of care requirements imposed upon nursing home owners and operators. Medicaid reimbursement rates have been unreasonable and inadequate at least since April, 1987; and, nursing homes have had substantial difficulty meeting federal and state quality of care requirements since mid-1987.

Finding of Fact 26, Appendix C, at C-9. *See also Wilder*, 496 U.S. at 519 n.17 (state must pay cost of complying with quality of care requirements); *Abbeville Gen. Hosp.*, 3 F.3d at 805; *Bradley*, 983 F.2d at 1465; *Arkansas Medical Soc'y*, 6 F.3d at 529-31; *Demps*, 816 F. Supp. at 701; *Folden* v. *Washington State Dep't of Social & Human Servs.*, 744 F. Supp. 1507, 1534 (W. D. Wash. 1990), *aff'd*, 981 F.2d 1054 (9th Cir. 1992); and *Dunning*, 778 F.2d at 1294.

The Indiana Supreme Court, however, never even mentioned the statutory relationship between payment and the nursing homes' ability to comply with care standards. The court wholly ignored the trial court's numerous and detailed findings that the rate-setting methodology violated federal law because quality care could not be provided at the rates paid by the Indiana Medicaid program. *Compare* Findings of Fact 26, 33, 69, 71, 76, 79 and 85, and Conclusions of Law 28, 29, and 33 *with* the decision of the state supreme court. Appendices C and A, at C-9-C-10, C-20-C-24, C-26-C-27, C-43-C-45.

### 4. The Indiana Supreme Court Erroneously Evaluated the State Defendants' Substantive Compliance with the Boren Amendment by Focusing on the Adequacy of a Single Rate Component.

Federal law is clear, as the state trial court below recognized and held, that the legality of a Medicaid rate is determined by whether the rate *as a whole* is adequate, and not by examining the reasonableness of the individual components of the rate-setting system. This is because a rate is composed of many individual costs, e.g., dietary costs, capital costs, nursing costs, etc., and one inadequate rate component may be offset by a generous component, so it is irrelevant whether any one specific component is adequate or inadequate. *See, e.g., Colorado Health Care Ass'n*, 842 F.2d at 1167; *Kansas Health Care Ass'n*, 822 F. Supp. at 690; *Folden*, 744 F. Supp. at 1535; *Anco, Inc.* v. *State Health & Human Servs. Fin. Comm'n*, 388 S.E.2d 780, 784 (S.C. 1989); *cf. Duquesne Light Co.* v. *Barasch*, 488 U.S. 299, 313-14 (1989) ("Inconsistencies in one aspect of the [utility rate-setting] methodology have no constitutional effect . . . if they are compensated by countervailing factors in some other aspect"). Properly applying this principle, the state trial court held that several rate components combined to make the total rate unreasonable. *See, e.g.*, Findings of Fact 58, 59 and Conclusions of Law 28-31, 33, Appendix C, at C-17, C-43-C-45.

In contrast, the Indiana Supreme Court's discussion of the substantive adequacy of Indiana Medicaid payments is limited entirely to discussion of one rate-setting component—an inflation factor known as the GNP/ipd. Appendix A, at A-18-A-21. The Indiana Supreme Court does not discuss or dispute—or even mention—any of the factual findings or legal conclusions of the trial court with respect to the adequacy of the rate as a whole or with respect to the impact of other rate limitations. *See* Conclusion of law 31, Appendix C, at C-44 ("entire reimbursement system" violates Boren Amendment), and Conclusion of Law 28, Appendix C, at C-43 ("payment rates violated Boren Amendment for several reasons").

### C. A Writ of Certiorari Should Issue to Resolve the Conflict Between the Decision of the Indiana Supreme Court and the Decisions of This Court and Other Federal Courts.

The question presented by this petition is not whether this Court would agree or disagree with the ultimate resolution of the merits of plaintiffs' federal claims by the state courts. The issue is whether state courts have authority to decide federal claims pursuant to decisional principles that conflict with federal statutory law and with settled federal law recognized by this Court and by the lower federal courts.

In each of four critical areas, the Indiana Supreme Court ignored outcome-determinative principles of federal law set forth in the federal statute and in the decisions of the federal courts. If the state courts are permitted to redefine the elements of federal causes of action in ways that conflict with federal statutes and case law, as occurred here, the federal statutory rights created by Congress have no substance. In the context of a federal statute, such as the Medicaid Act, that creates a program providing hundreds of millions of federal dollars annually to the State of Indiana for the express purpose of assuring that sick and impoverished elderly and disabled persons receive quality health care, the need to assure that the federal guarantee is properly enforced against state defendants by state courts is especially urgent and compelling.

Yet, this case ought not to be viewed as a Medicaid case. The question at issue in this petition is as basic as it is important to our federal system: must state courts accord federal law preeminence over state policies and law even where enforcement of federal rights may require state courts to order state defendants to provide costly, burdensome or unpopular relief to victims of their illegal conduct?

This issue has arisen frequently in the past and is likely to arise more and more frequently in a broad and unpredictable variety of federal law contexts because, as a general rule, state courts have concurrent jurisdiction along with federal courts to

enforce rights created by federal statutes.[18] Further, because of constitutional and statutory limits on the jurisdiction of the federal courts, the state courts often are the only forum capable of providing complete relief for violations of federal law. Yet, state courts will never be fully utilized by federal question litigants or viewed as effective arbiters or enforcers of federal law unless it is clear that state courts are required to accord settled interpretations of federal law by federal courts at least as much deference as the federal courts are required to accord to state courts on questions of state law. The decision of the Indiana Supreme Court, if left standing, will encourage conflict between the state courts and the federal courts, and will erode fundamental principles of comity and federalism.

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[18] *See, e.g., Dice* v. *Akron C&Y R.R.*, 342 U.S. 359 (1952) (Federal Employers Liability Act); *Brown* v. *Western Ry.*, 338 U.S. 294 (1949) (same); *Mondou* v. *New York, H.H. & H.R.R.*, 223 U.S. 1 (1912) (same); *Garrett*, 317 U.S. 239 (1942); (Jones Act); *Charles Dowd Box Co.* v. *Courtney*, 368 U.S. 502 (1962) (Labor Management Relations Act); *Maine* v. *Thiboutot*, 448 U.S. 1 (1980) (Civil Rights Act).

## IV. CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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January 26, 1994

## APPENDIX A

IN THE

# Indiana Supreme Court

INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, SUZANNE MAGNANT, in her capacity as ADMINISTRATOR OF INDIANA DEPARTMENT OF PUBLIC WELFARE,

*Appellants,*

*v.*

TIOGA PINES LIVING CENTER, INC., COMMUNICARE OF INDIANA, INC., D/B/A AMERICAN VILLAGE RETIREMENT COMMUNITY BLOOMINGTON CONVALESCENT CENTER, INC., MEADOW HEIGHTS NURSING CENTER, INC., D/B/A LINCOLN HILLS OF NEW ALBANY,

*Appellees.*

No. 30S01-9208-CV-00621
in the Supreme Court

No. 30A01-9201-CV-008
in the Court of Appeals

---

INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, SUZANNE MAGNANT, in her capacity as ADMINISTRATOR OF INDIANA DEPARTMENT OF PUBLIC WELFARE,

*Appellants,*

*v.*

COMMUNITY CARE CENTERS, INC., and the INDIANA HEALTH CARE ASSOCIATION,

*Appellees.*

No. 30S01-9208-CV-00621
in the Supreme Court

No. 30A01-9201-CV-008
in the Court of Appeals

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APPEAL FROM THE HANCOCK CIRCUIT COURT
The Honorable Ronald L. Gottschalk, J.
Cause No. 30C01-9002-CP-00125

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APPEAL FROM THE BLACKFORD CIRCUIT COURT
The Honorable Bruce C. Bade, J.
Cause No. 05C01-8808-CP-085

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ON PETITION TO TRANSFER

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DEBRULER, J.

The plaintiff nursing homes in these two appeals (hereinafter, collectively, "Providers") successfully challenged the Medicaid reimbursement system in Indiana. Defendants, Indiana State Board of Public Welfare, Indiana Department of Public Welfare, [1] and Suzanne Magnant, in her capacity as Administrator of the Indiana Department of Public Welfare (hereinafter, "the State"), appeal from adverse judgments rendered in the Hancock Circuit Court and the Blackford Circuit Court. The Court of Appeals consolidated the pending two appeals in accordance with Ind. Appellate Rule 5(B), since there are common questions of law and fact. Because these appeals involve a question of law of substantial public importance requiring an early determination, this Court took jurisdiction of the consolidated appeal from the Court of Appeals pursuant to App. R. 4(A)(10) (now App. R. 4(A)(9)). This Court held oral argument on April 28, 1993.

The class action captioned *Tioga Pines Living Center, Inc.* v. *Indiana State Board of Public Welfare* was brought on behalf of

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[1] Prior to 1992 the Indiana Department of Public Welfare (DPW) was the state agency designated to administer the Medicaid program. DPW has now become the Division of Family and Children of the Family and Social Services Administration, and the Office of Medicaid Policy and Planning was created to administer Medicaid. *See* I.C. § 12-8-6-1 and § 12-15-1-1 (Burns 1992).

approximately 785 Medicaid-certified, skilled nursing facilities and intermediate care facilities in Indiana. The complaint was filed pursuant to 42 U.S.C. § 1983 and Ind. Code § 34-4-10-1, *et seq.*, known as the Indiana Declaratory Judgment Act. The Hancock Circuit Court, Ronald L. Gottschalk, J., entered a "Partial Final Judgment Entry" on March 25, 1992, from which the State appeals. The major elements of the partial final judgment are as follows:

> 1) the State's Medicaid reimbursement rules violated the federal Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A), and its state counterpart, I.C. § 12-1-7-17.6(b), because the reimbursement rules employed the Gross National Product implicit price deflator (GNP/ipd) as a cap upon any annual reimbursement rate increase;
>
> 2) the use of the tests of reasonableness in setting reimbursement rates was invalid, because the tests were never duly promulgated;
>
> 3) because of the illegalities of the reimbursement regulations, class members were under-reimbursed their reasonable costs in providing care in conformance with federal and state regulations;
>
> 4) the State should repay class members for all under-reimbursement from January 24, 1988 to March 31, 1991;
>
> 5) the State is liable for the class' and intervenor's attorney fees and expenses in the amount of $565,000.00 and $667,907.00, respectively, pursuant to 42 U.S.C. § 1988; and
>
> 6) the class' counsel is entitled to attorney fees in the amount of 25% of the fund created pursuant to Ind. Trial Rule 23(D), or $10,075,079.00, plus expenses.

A procedure was set up whereby each class member could present a claim against the fund to a court appointed Master and for the State to challenge the Individual claims.

In the case captioned *Community Care Centers, Inc.* v. *Indiana State Board of Public Welfare*, plaintiff nursing homes sought declaratory and injunctive relief pursuant to Indiana statutory provisions. The Blackford Circuit Court, Bruce C. Bade, J., entered three orders granting partial summary judgment, dated May 17, 1990, January 15, 1991 and December 16, 1991. The State appeals all three orders.

The May 17, 1990 partial summary judgment enjoined the State from utilizing the rules promulgated in 1988, the "tests of reasonableness,"[2] because there was an absence of a quorum present at the Board of Public Welfare meeting at which the tests were promulgated.

The January 15, 1991 partial summary judgment enjoined the State from using the GNP/ipd maximum annual rate increase limiter as the sole determinant in setting nursing home rates. In its January 15, 1991 partial summary judgment order, the trial court incorporated its findings and conclusions from a previous order granting Community Care a temporary restraining order on this same issue. In that TRO, dated June 5, 1990, the trial court found that although the State applies five rate limiters to a provider's calculated rate, the GNP/ipd limiter may be the sole determinant of a provider's reimbursement rate.

The December 16, 1991 summary judgment enjoined the State from using certain aspects of the tests of reasonableness. Specifically, the State was enjoined from making line item comparisons and comparisons without regard to size in setting Community Care's reimbursement rates.

The effect of the summary judgments is that in setting rates for the Community Care facilities, the State is prohibited from using the tests of reasonableness or GNP/ipd limiters and is required to make comparisons taking into account size of facilities.

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[2] The details of the tests of reasonableness are codified at 470 IAC 5-4.1-10(3) (1988).

The following issues are raised on appeal:

(1) whether the trial courts were in error in concluding that the State employed an illegal methodology due to the use of the GNP/ipd annual rate increase limiter and the tests of reasonableness in determining Medicaid reimbursement rates;

(2) whether the trial court in *Tioga Pines* was in error in awarding damages; and

(3) whether the *Tioga Pines* trial court's attorney fees award was proper.

Congress established the Medicaid program in 1965. It is a government program, jointly administered by the states and the federal government, designed for assuring payment for health care given those who cannot pay. Hospital care, nursing home care, physician services, and medicines are included. Annual Medicaid payments in Indiana total several billion dollars. The burden of these payments on a participating state, such as Indiana, has been assumed by both the state and the nation as a whole, the federal government paying the greater share. The state bears the primary responsibility for initially establishing a state plan conforming to federal requirements; however, this function is subject to oversight and approval by the federal government through the Health Care Financing Administration ("HCFA"). *See generally*, Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 Ohio State L.J. 855 (1990) [hereinafter *Medicaid Program*].

The State's reimbursement plan comprises its detailed rules and regulations promulgated pursuant to authority granted by statute. The State's authority to make such rules and regulations during the years 1978, 1983, and 1988, when amendments and

publications of the rules having particular relevance to these cases were promulgated, was delegated to the State in a 1936 statutory provision:

> [The state department] may make such rules and regulations and take such action as may be deemed necessary or desirable to carry out the provisions of this act and which are not inconsistent therewith.

Burns Ann. Ind. Stat. § 52-1104(f) (1964 Repl.)[3] Providers did not challenge this delegation of authority, but based their claims upon the proposition that the DPW's rules and regulations were not valid.

It is elementary that the authority of the State to engage in administrative action is limited to that which is granted it by statute and that administrative action within such limitation has the force of law. *Blue* v. *Beach* (1900), 155 Ind. 121, 56 N.E. 89. Administrative action is often categorized as either rulemaking or adjudicatory. *Blinzinger* v. *Americana Healthcare Corp.* (1984), Ind. App., 466 N.E.2d 1371. Rulemaking includes the process of formulating or adopting a rule. I.C. § 4-22-2-3 (Burns 1993). The challenged action here involves rulemaking as opposed to adjudication. Rulemaking is not subject to judicial review under the provisions of the Administrative Adjudication Act, I.C. § 4-22-1-1, *et seq.*. *Indiana Environmental* v. *Indiana-Kentucky Elec.* (1979), 181 Ind. App. 570, 393 N.E.2d 213. However, rulemaking is not exempt from judicial review. *Gross Income Tax Div.* v. *Colpaert Realty Corp.* (1952), 231 Ind. 463, 109 N.E.2d 415, 422. Courts exercise a greater degree of self-restraint when reviewing agency rulemaking as the process may involve a generally applicable interpretation of the basic public purpose of the

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[3] This statute has been reformulated and recodified a number of times. The reformulation applicable in 1988 read:

> [The state department] may make such rules and take such actions as are necessary or desirable to carry out this article and which are not inconsistent with this article.

I.C. § 12-1-2-3(f) (Burns 1988). This statute was repealed in 1992.

governing statute, and it is not desirable to unduly restrict the freedom of the agency to do that. A similar self-restraint is appropriate in adjudicatory reviews. *Indiana Department of Public Welfare* v. *Payne*, No. 49S02-9310-CV-1112, 1993 WL 409982 (Ind. Oct 18, 1993). The State does not defend these challenges on the basis that there was any failure to exhaust administrative remedies before entering court.

The state plan for Medicaid reimbursement to Providers is a complex agency rule resolving a major issue in society. The plan bridges the gap between broad congressional and legislative statements of purpose and individual recipients and providers. The rule has also been approved at various stages by the HCFA on behalf of the state-federal partnership. The scope of judicial review under state law is narrow and the agency's action will not be overturned unless it is purely arbitrary or an error of law has been made. *Wallace* v. *Feehan* (1934), 206 Ind. 522, 190 N.E. 438; *Blue*, 155 Ind. 121, 56 N.E. 89; *City of Indianapolis* v. *Ingram* (1978), 176 Ind. App. 645, 377 N.E.2d 877. On appeal from the judgment of the trial court, its resolution of any factual issues will be sustained if supported by substantial evidence; however conclusions of law are reviewed for error. *Pendleton Banking Co.* v. *Dept of Financial Inst.*, (1971), 257 Ind. 363, 274 N.E.2d 705; *Ingram*, 176 Ind. App. 645, 377 N.E.2d 877.

Judicial review in state courts of this state plan includes consideration of whether it complies with federal law. *Arkansas Medical Society, Inc.* v. *Reynolds*, Nos. 92-3146/93-2352, 1993 WL 341165 (8th Cir. Sept. 10, 1993). Federal standards governing judicial review of state Medicaid plans do not differ substantially from state standards. Since Providers here challenge the State's reimbursement system, they have the burden of demonstrating to the court that the rates received under the State's system were the product of an unreasonable interpretation of the statute, falling outside the zone of reasonableness. *See Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990); *Lett* v. *Magnant*, 965 F.2d 251 (7th Cir. 1992); *Wis. Hosp. Ass'n* v. *Reivitz*, 733 F.2d 1226, 1233 (7th Cir. 1984).

There are two separate parts to the federal Boren requirement, one procedural and the other substantive. When the issue is substantive compliance, a court must employ a more deferential standard of review. *Wilder*, 496 U.S. at 520 n. 18, 110 S.Ct. at 2523 n. 18, 110 L.Ed.2d at 473-74. So long as an agency is exercising its discretion, courts must defer to the agency's expertise. *AMISUB (PSL), Inc.* v. *Colorado Dept. of Social Services*, 879 F.2d 789 (10th Cir. 1989), *cert. denied*, 496 U.S. 935, 110 S.Ct. 3212, 110 L.Ed.2d 660 (1990).

The *Community Care* litigation resulted in the entry of three summary judgments. On appeal, summary judgments, like all judgments, are clothed with the presumption of validity. *Dep't of Revenue* v. *Caylor-Nickel Clinic* (1992), Ind., 587 N.E.2d 1311. The party appealing from the grant of summary judgment has the burden of persuading the appellate tribunal that the trial court erroneously determined that there is no material issue of fact and that the movant was entitled to summary judgment as a matter of law. *Jordan* v. *Deery* (1993), Ind., 609 N.E.2d 1104. The reviewing court faces the same issues that were before the trial court and follows the same process. *Id.* All properly asserted facts and reasonable inferences should be resolved against a moving party. *Cowe* v. *Forum Group, Inc.* (1991), Ind., 575 N.E.2d 630, 633. The judgment of the trial court will be affirmed on appeal if sustainable on any basis. *Havert* v. *Caldwell* (1983), Ind., 452 N.E.2d 154.

The summary judgment motions granted by the *Community Care* trial court had been filed by Providers. While the State, as the appealing party, has the burden of persuasion, the essential issue for this Court remains whether the Provider as moving party has established the lack of material factual issue dispositive as a matter of law. Thus, the burden was upon Providers in the trial court to establish that there was no nexus between the costs of operating efficient and economical nursing facilities and the rates under the State's plan.

Effective in 1976, Congress required Medicaid payments to Providers to be calculated on the basis of a plan using

> a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary

42 U.S.C. § 1396a(a)(13)(E) (Supp. III 1979). This has been referred to as the reasonable cost standard. The Indiana statute was amended to correspond with this standard. The statute required payments to be determined in accordance with

> a [prospective] pre-negotiated payment rate predicated on a reasonable cost-related basis, with a growth or profit factor, as determined in accordance with generally accepted accounting principles and methods, and written standards and criteria, as established by the state department of public welfare.

I.C. § 12-1-7-17 (1976). Pursuant to these enactments, the State adopted its rule establishing a prospective, pre-negotiated system of payment predicated on reasonable cost. Under the rule, each year, every provider was entitled to have an individual rate set on a fact specific basis. The rule did not impose an actual cost cap, but of particular pertinence to this appeal, it did impose five caps on any annual rate increase, including the following three:

> (I) Market Area Limitation. This ceiling is determined for each of the 6 classes, and is established as 135% of the average allowable (weighted as appropriate) for each class.
>
> (II) Incentive Payment Limitation. Providers whose allowable costs are less than the Market Area Limitation of their class (as described in I) may retain 30% of the difference as an incentive factor for efficient operations, subject to application of limitations III, IV and V below.
>
> (III) Annual rate increase limitation. The maximum allowable increase in a provider's average Medicaid rate will not be greater than nine percent (9%) of their

> previously approved rate per any twelve (12) month period beginning July 1, 1976, and adjusted pursuant to the directives of the State Department of Public Welfare. The maximum allowable increase will be calculated on one increase, or the aggregate of the two increases per year as provided herein.

470 IAC 5-4-5(2)(I)-(III) (1979). The above payment system, based upon the idea of reasonable costs, was approved by the Secretary of Health, Education and Welfare, and upon it Providers had their reimbursement payments calculated until the early 1980s.

In 1981 Congress substituted a new standard as part of the Boren Amendment to the Medicaid Act to govern the calculation of Medicaid payments due Providers. This standard provides that payments must be set at a rate which is

> reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 U.S.C. § 1396a(a)(13)(A) (Supp V 1981). This is the standard that was applicable to the process of determining the rates for payments due Providers in these cases.

Through this modification of the federal standard, Congress afforded states greater flexibility in calculating reimbursement rates. *Wilder*, 496 U.S. at 506, 110 S.Ct. at 2516, 110 L.Ed.2d at 465. In reflecting upon this change of course, one court has observed:

> Because of rapidly escalating Medicaid costs, Congress reevaluated this approach [reasonable cost] in the early 1980s. Congress eventually concluded that the complexity, rigidity and "inflationary nature" of the reasonable cost reimbursement system was to blame for the program's rising costs. Accordingly, Congress enacted Boren in 1981, replacing the reasonable cost provision

> with "a provision requiring States to reimburse hospitals at rates . . . that are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities . . . "
>
> . . .
>
> The Boren Amendment was enacted with two specific purposes in mind: (1) to provide the states with greater flexibility in developing methods of reimbursing skilled nursing facilities, intermediate care facilities, and inpatient hospital services; and (2) to increase the economy and efficiency of all plans.
>
> . . .
>
> Boren therefore creates a tension between the need to creatively cut costs and stimulate the efficiency of providers, and the obligation to provide adequate care to Medicaid patients.

*Dep't of Health and Social Servs.* v. *Alaska State Hosp. and Nursing Home Ass'n*, 856 P.2d 755, 758-759 (Alaska 1993) (citations omitted).

With the reduction of federal funds to be paid under the Medicaid program, the change in the federal standard enabled states to create reimbursement plans which would encourage cost containment in the health/medical field. *Reivitz*, 733 F.2d at 1228; *Medicaid Program* at 871.

Indiana responded to the Boren Amendment by amending its statute governing payment to Providers, abandoning the existing reasonable cost standard, and tracking the standard of the Boren Amendment. The Indiana statute provided:

> Payment . . . shall, under 42 U.S.C. § 1396a(13)(A), be determined in accordance with a prospective, renegotiated payment rate that is reasonable and adequate

> to meet the costs that are incurred by efficiently and economically operated facilities in order to provide care and services in conformity with state and federal laws, rules, regulations, and quality and safety standards. . . .

I.C. § 12-1-7-17.2 (Burns 1984). This Indiana statutory counterpart was applicable to the judgments considered in this appeal and is virtually identical to the Boren Amendment.

In 1983, the DPW also responded to Boren and the Indiana statutory amendment by amending the form of its prior rule. The newly-amended provision provided:

> The procedures delineated in 470 IAC 5-4.1 set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. . . . The system of payment outlined in 470 IAC 5-4.1 is a prospective system predicated on a reasonable, cost-related basis. *However, cost limitations are contained in 470 IAC 5-4.1 which establish parameters regarding the allowability of costs.* . . .

470 IAC 5-4.1-1(b) (1984) (emphasis added). The State also added the following:

> In determining reasonableness of costs, the department may compare major cost centers or total costs of similar providers in the state and may request satisfactory documentation from providers whose cost does not appear to be reasonable. Similar providers are those with like level of care, size and geographic location.

470 IAC 5-4.1-10(d) (1984) (hereinafter referred to as "the tests of reasonableness").

In 1983, the State also modified the five caps upon annual rate increases. The three major caps from the pre-Boren Amendment rule were modified as follows:

> The MAL [market area limitation] is an amount which shall be 140% of the average allowable cost, weighted by certified beds, for the same type of providers. . . . Providers whose allowable costs are less than the MAL . . . may retain a percentage of the difference as an incentive factor for efficient operation.

470 IAC 5-4.1-9(c)(1) (1984).

> The calculated rate is the sum of the allowed costs and the add-on incentive. The add-on incentive is a percentage of the difference between the MAL and allowable cost, if allowable cost is less than the MAL. The provider shall be paid at the calculated rate if such a rate does not exceed any of the other limitations outlined herein.

470 IAC 5-4.1-9(c)(2) (1984).

> The maximum allowable annual rate increase for the twelve (12) months following April 1, 1983, shall not be greater than the average rate of change, expressed as a decimal, of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator.

470 IAC 5-4.1-9(c)(3) (1984). The two features of the plan methodology to which Providers object in their 1988 and 1990 lawsuits were introduced into the plan in 1983, soon after the enactment of the federal Boren Amendment. The State tightened the annual rate increase limiter from 9% to the GNP/ipd or general rate of inflation in the economy as a whole, and introduced the tests of reasonableness, to be applied to the cost factor. 470 IAC 5-4.1-5 exempted the process of determining the initial and base rates of reimbursement for a provider from application of the GNP/ipd annual rate limiter.

In 1988, the state plan was amended and assumed the form in which it was applied to Providers in this appeal. The GNP/ipd annual rate limiter was retained in the plan undisturbed. The cost reasonableness language was changed to provide:

> In determining reasonableness of costs, the department may compare line items, major cost centers or total costs of similar providers in the state and may request satisfactory documentation from providers whose cost does not appear to be reasonable. Similar providers are those with like level of care and geographic location.

470 IAC 5-4.1-10(d) (1988). Also in 1988, further details of the tests of reasonableness were set forth at 470 IAC 5-4.1-10(e).

At the core of the state plan, as applied to Providers in these cases, is the methodology for establishing an initial or base rate for a provider. Pursuant to the 1983 and 1988 Rules, such first or base rate is established upon a pre-Boren type reasonable cost standard, without application of the GNP/ipd limiter. Providers make no complaint about the methodology for setting this rate. The rate is applicable for twenty-two months after it is set. The rule permits a participating provider to thereafter request and, if adequate support for such request is given, to receive a rate increase once each year. Pursuant to the GNP/ipd limiter, such annual rate increases cannot exceed the general rate of inflation in the economy as a whole.

The details of the tests of reasonableness, as promulgated in 1988, provide for a three level approach to costs: 1) the first level is a general line item review wherein DPW reviews each budgeted item for a provider with the previous years data on that item; 2) the second level is a per diem comparison by cost centers; and 3) the third level is a per diem comparison between providers in the same geographic area. All providers are separated into one of three geographic areas. The second and third levels would be performed only on providers that exceeded the 75th percentile of all homes in total per diem costs.

Under the plan, once the budgeted allowable costs are determined, a bonus incentive payment is added to it to determine the "calculated rate." The incentive payment is a percentage of the difference between budgeted allowable costs of the facility and 140% of the average budgeted allowable costs of similar facilities in the same geographic area. 470 IAC 5-9(c)(1) (1988). Once the calculated rate is determined, rate limiters are applied to determine the final rate for the upcoming year. The GNP/ipd is one such rate limiter.

The grievance in both *Tioga Pines* and *Community Care* is to be determined from an examination of the judgments themselves. The gravamen in each case is the same, namely: 1) the employment of the GNP/ipd annual rate limiter in the state plan methodology for calculating nursing home reimbursement for Medicaid services renders the plan violative of the requirements of the governing federal law and state law; and 2) there is no authority of the state to employ tests of reasonableness adopted in 1988 because such tests were not lawfully promulgated. The remedy afforded by the judgments in each case gives final delineation to the illegalities which are the bases of the judgment. In each case, the curative measure is the excision of an offending part of the state plan and an enforcement of the remaining part. With respect to the GNP/ipd annual rate limiter, the illegality upon which the judgment is based is clearly substantive.

**A. Tests of Reasonableness**

Beginning in 1983, the State used the three-level tests of reasonableness. The State argued at trial that the nursing home industry was aware of the use of the tests in 1983, including the detailed steps, and it was the industry's preference that the detailed steps not be promulgated as rules at that time.

On June 28, 1988, the State Board of Public Welfare met to formally promulgate the details of the tests of reasonableness. The Board is a seven-member board, but only three members were physically present at the June 28, 1988 meeting. However, two members had given their written proxies to one of the members who was present. The Board's enabling statute stated, in part:

> There is created a state board of public welfare, which shall be appointed by the governor and consists of seven (7) members . . . . Four (4) members of the board constitute a quorum for the transaction of business . . . .

I.C. § 12-1-15-2 (Burns 1988) (repealed 1992). The statute did not mention proxies and there was no agency rule mentioning proxies.

The *Tioga Pines* trial court found the use of the tests of reasonableness an illegal aspect of the Medicaid reimbursement regulation because it was never duly promulgated. Therefore, the court found it contributed to the Providers' under-reimbursement.

In ruling on a summary judgment motion filed by the Indiana Health Care Association, the *Community Care* trial court likewise found the use of the tests of reasonableness illegal, because they were never duly promulgated. The *Community Care* trial court concluded that no quorum was present at the Board meeting of June 28, 1988; thus, the rules were void. The trial court permanently enjoined the State from utilizing such rules.

In general a proxy is one who has the same authority to act and vote as does the member. As noted, the use of proxies is not contrary to the delegating statute in these appeals. Some Indiana statutes expressly sanction the use of proxies. I.C. § 3-6-4-6 (State Election Board); I.C. § 36-7-6-9 (Maumee River Basin Commission). Some statutes expressly forbid the use of proxies. I.C. § 13-2-27-5 (Rivers Commission Act); I.C. § 8-1-2.7-7 (Local

Water Corporations). The statute applicable here sanctions rules "necessary or desirable" to carry out the delegated duties and not inconsistent with such duties. I.C. § 12-1-2-3 (Burns 1988).

This Board is composed of volunteer citizens from around the state and it is natural to suppose that difficulties would be met from time to time achieving a live quorum for the conduct of official business. This Board employed written proxies of record. This Board in promulgating this rule did not chart an entirely new administrative course. The record in this case establishes that this Board has applied the tests of reasonableness at least since 1983. Providers knew of the tests' existence, received payment under the system with application of the tests for at least five years prior to bringing suit, and did not initiate a challenge. Providers challenge only the procedural aspect of the tests' promulgation and make no claim against the substantive aspect of the tests. The promulgation of this amendment by this Board was subject to further federal consideration and oversight. Providers do not identify an impingement upon any special right or interest other than the interest in procedural compliance.

Clearly there is a preference implicit in the very concept of official government action of live personal participation by public officials. At the same time, the choice of procedural methods by agencies, if not arbitrary or contrary to law is entitled to judicial deference upon review, particularly in the area of rulemaking. The departure here from the preference for live personal participation in official action by a quorum, is an irregularity, the harm of which (if existing) was healed by review rights and the further action at federal levels. Under these circumstances, it was error to invalidate the 1988 promulgation. Providers are not entitled to injunctive relief.

**B. GNP/ipd**

Providers presented evidence to the *Tioga Pines* trial court regarding the GNP/ipd maximum annual rate limiter. This evidence can be summarized as follows:

Rosacker, CPA, testified that 91.14% of facilities to which the GNP/ipd was applied in 1989, and 88.79% in 1990 had their rates limited by the GNP/ipd.

Deane, economist, testified that the GNP/ipd is not an appropriate index of cost for the nursing home industry, because it does not relate to the nursing home industry, does not address itself to the geographic area or time period in question, and is a price index and not a cost index. Deane stated the GNP/ipd was the best measure of inflation of all goods and services produced in the economy.

Blinzinger, former DPW Administrator, testified that DPW had initially recommended the medical component of the Consumer Price Index as the index to determine the maximum annual increase, but that index was rejected by the Governor in favor of the GNP/ipd as recommended by the State Budget Agency. Blinzinger further testified that the nursing home industry was "intimately and comprehensively" involved in the development of the new criteria in 1982-83, and agreed that an annual limiter was a requirement. Blinzinger stated that although the industry actively made their views known to him between April 1983 and early 1987, he did not receive any complaints about the use of the GNP/ipd or the overall level of reimbursement.

Jazwiecki, CPA, testified that the GNP/ipd loses its relevancy to the actual costs incurred by the providers, because it has no relationship to the costs incurred during that time period. His testimony is that because the GNP/ipd has no relationship to actual costs incurred, the gap between rates paid and costs incurred increases. Jazwiecki testified that in 1987, 41.2% of facilities did not receive rates which covered their "actual allowable costs" and by 1990, 70.6% of facilities did not.

Johnson, nurse and college professor, testified that in her experience the trend is that nursing home residents are "sicker and more dependent." Although she conceded that she had not studied Indiana nursing homes in particular, she believed Indiana would be "no different than anyplace else" in this regard. She also testified that "a large number of facilities" in Indiana had difficulty meeting quality of care standards between 1987 and 1990.

Buoy, CPA, testified that there are two ways for an existing facility to escape application of the GNP/ipd: 1) change of ownership, which includes selling or leasing facilities; and 2) capital expenditures, which results in adjustment of the GNP/ipd under certain circumstances. Buoy testified that of the 249 transactions since 1987, the majority (177) have involved leasing of facilities instead of outright selling of facilities. Buoy further testified that between 1985 and 1990, the GNP/ipd increased between 2.8 and 3.8% annually.

Engquist, management consultant, testified that a flaw in the cost containment system in Indiana is the serious problem with changes of ownership. Engquist further testified that the GNP/ipd was an appropriate limiter for achieving the objectives of a prospective payment system.

Other courts have ruled upon the question of whether a state plan satisfies Boren Amendment substantive standards. In *Ohio Hosp. Ass'n* v. *Ohio Dept. of Human Services,* 579 N.E.2d 695 (1991), a state plan amendment reducing a reimbursement rate to 88% of reasonable costs was held violative of the Boren Amendment and state law, because it was implemented solely for budgetary reasons, without consideration of its effect on the quality of care. A U.S. district court of appeals invalidated a plan where the state used a "budget adjustment factor" to divide its median cost of care in half. *AMISUB,* 879 F.2d 789. A federal district court enjoined Illinois from deferring 23.5 percent of the amount calculated pursuant to its final hospital reimbursement rate, because the plan failed to satisfy the federal requirement

that Medicaid reimbursement rates be sufficient to ensure quality care. *Illinois Hosp. Ass'n* v. *Illinois Dep't of Pub. Aid*, 576 F. Supp. 360 (N.D. Ill. 1983). Another district court preliminarily enjoined a plan that limited current year reimbursement to previous year allowable costs, plus 1% for inflation. *Kansas Health Care Ass'n* v. *Kansas Dep't of Social and Rehab. Servs.*, 822 F. Supp. 687 (D. Kan. 1993).

Providers persuaded the trial courts that the GNP/ipd was unrelated to nursing home care, and was essentially and impermissibly budget-driven. Providers argued that the GNP/ipd was chosen by the State Budget Agency to effectively set the reimbursement rate at 90% of the class. The *Tioga Pines* trial court found the use of the GNP/ipd maximum annual rate limiter was an illegal aspect of the Medicaid reimbursement regulation because Providers were under-reimbursed for their reasonable costs.

The *Community Care* trial court also found the State's reimbursement rate inadequate under the state statute.[4] This determination was based on evidence similar to that in *Tioga Pines* relating to the use of the GNP/ipd. The *Community Care* trial court specifically found that the GNP/ipd was the sole determinant in arriving at a provider's rate. The trial court found this impermissible, and enjoined the State from using the GNP/ipd as the sole determinant.

These two cases fall outside the perimeters of the above cases, which have found substantive Boren Amendment violation. There was a percentage annual rate increase limiter atop the Indiana plan before the Boren Amendment. The Boren Amendment standard encourages the State to sharpen its focus

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[4] At the time *Community Care* was litigated in the trial court, Indiana's counterpart to the Boren Amendment was set forth at I.C. § 12-1-7-17.2 (Burns 1988). In 1990, I.C. § 12-1-7-17.2 was repealed and the language recodified at I.C. § 12-1-7-17.6.

upon industry behavior and take steps to encourage more efficient and economical operation within that industry. It encouraged change. The State chose to decrease its longstanding annual rate limiter from 9% to the general rate of inflation, that is between 2.8% and 3.8% during the time applicable here, such limiter to be applied to a cost-driven initial or base rate. The changed plan received federal approval and was applied to the industry for five years before it was challenged in court. The rate increase permitted by the GNP/ipd is greater than the 1% cap condemned in the *Kansas Health Care* case above. Unlike the other cases noted, annual increases in Indiana using prior year rates, including the cost-driven initial rate, and consistent with the general rate of inflation, continued to be available. To condemn Indiana's reimbursement system for nursing homes on this basis would be to eviscerate the purpose and intent of Boren and the purpose of Indiana's statute. To do so would merely collapse "the post-Boren language into the pre-Boren reasonable cost standard." *Lett,* 965 F.2d at 25.

The trial court was in error in concluding that the Providers established that there was no nexus between the costs of operating efficient and economical nursing facilities and rates under the State's plan with the GNP/ipd. Likewise, Providers failed to establish that the DPW's rulemaking was outside the confines of its duly delegated authority, or that the administrative action was arbitrary and capricious.

**C. Damages**

As discussed above, the State's use of the GNP/ipd as a maximum annual rate increase limiter and the tests of reasonableness were not improper. In light of the holding of this Court that illegality in the State's reimbursement methodology was not established, there can be no award of damages, equitable reimbursement or retroactive monetary award. Because we determine that the State's methodology was not illegal, we need not address whether the trial court had jurisdiction to award damages or whether the trial court used an erroneous measure of damages.

**D. Attorney Fees**

In addition to awarding damages to Providers, the *Tioga Pines* trial court also awarded attorney fees to class counsel and counsel for the intervenors (Cross-appellants). Class counsel was awarded $533,000.00 in fees and $32,000.00 for expenses, pursuant to 42 U.S.C. § 1988. Class counsel was also awarded 25% of the fund created by the judgment or $10,075,079.25 and $53,279.80 for expenses, pursuant to T.R. 23(D). Counsel for intervenors was awarded $548,361.00 in fees and $119,546.17 in expenses, pursuant to § 1988.

*1. 42 U.S.C. § 1988*

Section 1988 provides, in pertinent part:

> In any action or proceeding to enforce a provision of [section 1983] . . . the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs.

The State argues the trial court's award of fees and expenses pursuant to § 1988 is erroneous, because Providers were not "prevailing parties" on any § 1983 claims. Providers rely on *Hewitt* v. *Helms*, 482 U.S. 755, 107 S.Ct. 2672, 96 L.Ed.2d 654 (1987), as support for their argument that for purposes of § 1988, a party may prevail by voluntary action of a defendant. In this case, Providers argue they prevailed on their § 1983 claims, because the State voluntarily promulgated new rules in 1991.

Generally, in order to obtain an award of attorney fees, plaintiffs must prevail on the merits of their claims. *See Kentucky* v. *Graham*, 473 U.S. 159, 163, 105 S.Ct. 3099, 3104, 87 L.Ed.2d 114, 120 (1985). However, plaintiffs may be considered prevailing parties without obtaining a favorable final judgment following a full trial on the merits. Plaintiffs may prevail, for example, by consent decree or settlement which grants them the relief sought in bringing suit. *See, e.g., Hanrahan* v. *Hampton*, 446 U.S. 754, 100 S.Ct. 1987, 64 L.Ed.2d 670 (1980).

The United States Supreme Court recently has addressed the issue of what constitutes a "prevailing party" for purposes of § 1988. In *Farrar* v. *Hobby*, 506 U.S. , , 113 S.Ct. 566, 573, 121 L.Ed.2d 494, (1992), Justice Thomas, writing for the majority, stated:

> [T]o qualify as a prevailing party, a civil rights plaintiff must obtain at least some relief on the merits of his claim. The plaintiff must obtain an enforceable judgment against the defendant from whom fees are sought, or comparable relief through a consent decree or settlement. Whatever relief the plaintiff secures must directly benefit him at the time of the judgment or settlement. Otherwise the judgment or settlement cannot be said to affec(t) the behavior of the defendant toward the plaintiff. Only under these circumstances can civil rights litigation effect "the material alteration of the legal relationship of the parties" and thereby transform the plaintiff into a prevailing party.

*Id.* at (citations omitted).

As we have decided that Providers have failed to show a violation of the Boren Amendment, Providers have not prevailed by obtaining an "enforceable judgment." Further, there being no consent decree or settlement entered in this case, Providers have not established entitlement to "prevailing party" status with a resulting award of attorney fees pursuant to § 1988.

2. *Trial Rule 23(D)*

T.R. 23(D) provides in pertinent part:

> The court shall allow reasonable attorney's fees and reasonable expenses incurred from a fund recovered for the benefit of a class . . . .

The State and intervenors argue the trial court's award of 25% of the fund (approximately $30,000,000.00) to class counsel is an abuse of discretion. They contend the trial court erred in failing to use the lodestar method of calculating the award.

For the same reasons that we determined Providers were not prevailing parties entitled to § 1988 damages, we also determine the award of fees and expenses pursuant to T.R. 23(D) is erroneous. We do not address whether the trial court's award was otherwise erroneous.

**E. Conclusions**

The *Tioga Pines* judgment of the trial court entitled "Partial Final Judgment Entry," dated March 25, 1992, which awarded damages to the providers for under-reimbursement for the period January 24, 1988 through March 31, 1991, is reversed with instructions to grant judgment for the defendants. The further judgment of the trial court that providers recover attorney fees and expenses pursuant to 42 U.S.C. § 1988 is reversed, there being no right to attorney fees under that provision. The further judgment of the *Tioga Pines* trial court that class counsel recover 25% of the fund created pursuant to T.R. 23(D) or $10,075,079.25 is perforce reversed, there being no right to recover from such fund.

With respect to the judgment of the Blackford Circuit Court regarding the "Order on Motion for Partial Summary Judgment Filed by Indiana Health Care Association" of May 17, 1990, which enjoined the use of the tests of reasonableness because of a lack of legal promulgation, the judgment is reversed with instructions to grant partial summary judgment to defendants.

The January 15, 1991 "Order Granting Partial Summary Judgment to Plaintiff" of the *Community Care* trial court, which enjoins the use of the GNP/ipd as the sole determinant in setting Medicaid rates, is contrary to law and is reversed with instructions to grant summary judgment to defendants.

As for the December 16, 1991 "Order Granting Summary Judgment" filed by the *Community Care* trial court, this order was a declaratory judgment finding the State lacked promulgated authority to make line item comparisons and comparisons among providers without regard to size. This conclusion was based on a finding that LSA 88-33 was void as improperly promulgated. Because of our conclusion that LSA 88-33 is not void, this order must also be reversed with instructions to grant summary judgment for defendants.

Due to the final decisions in this appeal, no consideration of cross-errors need be given.

SHEPARD, C.J., and GIVAN, DICKSON, KRAHULIK, JJ., concur.

## APPENDIX B

| | | |
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| **State of Indiana**<br>**County of Hancock** | **SS:** | **In the Hancock Circuit Court**<br>**Cause Number:**<br>**30C01-9002-CP-0125** |

TIOGA PINES LIVING CENTER, INC., COMMUNICARE OF INDIANA, INC. D/B/A AMERICAN VILLAGE RETIREMENT COMMUNITY, BLOOMINGTON CONVALESCENT CENTER, INC., MEADOW HEIGHTS NURSING CENTER, INC., D/B/A LINCOLN HILLS OF NEW ALBANY,

*Plaintiffs,*

VS

INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, AND SUZANNE MAGNANT, IN HER CAPACITY AS ADMINISTRATOR OF THE INDIANA DEPARTMENT OF PUBLIC WELFARE,

*Defendants.*

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### JUDGMENT ENTRY

IT IS HEREBY ADJUDGED AND DECREED that the Medicaid reimbursement regulations which are the subject of this lawsuit violate the provisions of 42 U.S.C. 139b and of Inc. Code 12-1-7-17.s, in addition as was adjudged by this Court on February 7, 1991 a portion of the regulations were improperly promulgated. Damages are recoverable by the class for the period beginning January 24, 1988 and ending March 31, 1991. The amount of damages recoverable are defined to be the difference in Medicaid reimbursement calculated without the application

of the annual rate limiter (the GNP/ipd) or the "tests of reasonableness" which were determined to be illegally promulgated by summary judgment of this Court dated February 7, 1991 less the amount of Medicaid reimbursement actually paid. The calculation of damages for the period June 1, 1990 through March 31, 1991 has already been made by the Court on the basis of financial report statements filed by the Defendants with this Court on June 26, 1990 through March 31, 1991 is computed to be $40,800,317. The Court orders the parties to calculate and submit to the Court, within 30 days of this entry, a stipulation setting forth damages for the period of time January 24, 1988 through May 31, 1990. The calculation shall be made in a manner identical to that which was used to calculate the financial report statements which was filed with the Court on June 26, 1991.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the class, as well as the intervening Plaintiffs, are entitled to recover from the Defendants all attorney fees which they have become obligated to pay. The Court is not advised concerning the amount of attorney fees to be awarded and therefore sets this matter for hearing with respect to the amount of attorney fees on the 31st day of October, 1991 at 11:00 o'clock a.m.

Class counsel is entitled to attorney fees from the fund created by this judgment pursuant to the provisions of Trial Rule 23(b) of the Indiana Rules of Procedure. The extent of any such fee shall be determined by the Court and the hearing scheduled on the 31st day of October, 1991 at 11:00 o'clock a.m. Class counsel is ordered to notify all members of the class of the hearing by sending to each member of the class a copy of this judgment. Each member of the class is invited to participate at the hearing scheduled on the 31st day of October, 1991 at 11:00 o'clock a.m.

Within 10 days of this order, the parties are to exchange proposed forms to be used for the presentation of claims by individual class members to the Master appointed by this order. The claim form shall include copies of the forms submitted by

the class members to the State to obtain the reimbursement that was paid during the period for which damages are allowable herein. The forms shall also disclose the amount of reimbursement actually paid and shall calculate the difference between what was actualiy paid and what would have been paid on the basis of the budgets submitted if the annual limiter and tests of reasonableness were not applied to those budgets. The Court hereby advises that it will appoint a Master pursuant to Trial Rule 53 for the purpose of accepting claim forms and determining the amount of reimbursement to be paid to each class member. The parties are encouraged to submit to the Court names of people that they feel would be qualified to serve as Master. The procedure for filing claims is as follows:

1. Within thirty (30) days of this Court's approval of forms for the presentation of claims by individual class members the forms shall be distributed to each member of the class by class counsel.

2. Together with the forms, class counsel shall notify the members of the class that forms must be returned to the Master within sixty (60) days in order to qualify for participation in the distribution of damages awarded herein. The notice shall state that any claim received after sixty (60) days will be disallowed as untimely filed.

3. Immediately upon the receipt of claims by the Master, the Master shall forward copies of the claims to counsel for the class and counsel for the Defendants.

4. Immediately upon receipt of any claim, the Defendant may challenge the claim. The only challenges that may be made by the Defendant are challenges that budgeted items are either inefficient or not economic. To make a challenge the Defendant must state the budget item which is challenged, the dollar amount of that budget item it contends is due to inefficient or uneconomic operation and shall also specify the substance of its claim that the challenged expense was generated by inefficient or

economic. The Defendant may avail itself of any discovery process allowed by Indiana Rules of Trial Procedure in order to obtain information with which to substantiate its challenges. All challenges shall be completed and filed by the Defendant within one hundred eighty (180) days of the Defendant's receipt of the claim of each class member. Each class member whose claim is challenged by the State shall have ninety (90) days to respond to the challenge.

5. The Master shall pay any unchallenged claim within thirty (30) days of receipt.

6. The Master shall determine which challenges shall be allowed and to the extent a challenge is allowed, the Master shall file a report within thirty (30) days of his receipt of the claimant's response to the State's challenge indicating his acceptance of the challenge and the extent to which the claim will be reduced as a result of the challenge. The reduced claim shall be paid to the claimant immediately.

7. With respect to any claim which is challenged and the challenged amount not accepted by the Master, such claims shall be returned to the Court for resolution after an evidentiary hearing specific to the amounts claimed and the challenges thereto.

8. With respect to any challenged claim with respect to which the challenge is accepted by the Master and the claim thereby reduced, the holder of such a reduced claim shall, within fifteen (15) days of the Master's report, appeal to the Court for determination in the event that the claimant disagrees with the Master's determination. As with respect to challenged claims not accepted by the Master, such claims shall be resolved by the Court after an evidentiary hearing specific to the amounts of challenge allowed by the Master and disputed by the claimant.

This judgment shall not be considered a final appealable judgment until the Court has determined the amount of damages to which the class is entitled for the period January 24, 1988 through May 31, 1990 and until the Court has determined the amount of attorney fees owed by the Defendants.

ALL OF WHICH IS ORDERED, ADJUDGED AND DECREED this 18th day of September, 1991.

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JUDGE, HANCOCK CIRCUIT COURT

## APPENDIX C

| | | |
|---|---|---|
| **State of Indiana**<br>**County of Hancock** | **SS:** | **In the Hancock Circuit Court**<br>**Cause Number:**<br>**3OC01-9002-CP-125** |

TIOGA PINES LIVING CENTER, INC., COMMUCARE OF INDIANA, INC. D/B/A AMERICAN VILLAGE RETIREMENT COMMUNITY, BLOOMINGTON CONVALESCENT CENTER, INC., MEADOW HEIGHTS NURSING CENTER, INC., D/B/A LINCOLN HILLS OF NEW ALBANY,

vs. *Plaintiffs,*

INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, AND SUZANNE MAGNANT, IN HER CAPACITY AS ADMINISTRATOR OF THE INDIANA DEPARTMENT OF PUBLIC WELFARE,

*Defendants.*

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### FINDINGS OF FACT AND CONCLUSIONS OF LAW

Comes now the Court and enters the following findings of fact, conclusions of law and judgment:

### ADVISORY FINDINGS OF FACT

1. None of the parties requested proposed findings of fact and conclusions of law in accordance with the provisions of

TR 52(A), Indiana Rules of Procedure, this Court is only required to prepare and enter a general judgment. The Court previously indicated to all parties that this matter would be decided by a general judgment.

2. These findings are intended to be advisory only and are not considered by the Court as findings of fact and conclusions of law under TR 52(A); these findings are voluntarily entered by the Court to aid in understanding the issues tried, the judgment entered is considered by the Court as a general judgment, is entered separate from these findings and it is the intent and understanding of the Court that the entry of these voluntary findings of fact does not change the appellate standard of review of the general judgment entered. The Court herein adopts and incorporates by reference its prior findings of fact as to the preliminary injunction findings of May 29, 1990.

3. Subsequent to the evidence being concluded herein the Defendants promulgated new regulations which specifically repealed the regulations at issue before this Court. Those regulations became effective March 29, 1991. Thus, there is no further need for injunctive or declaratory relief concerning any portion of the regulation which was the subject of the trial herein. The only issue remaining for decision is whether or not the regulation was illegal and if illegal the extent to which the Plaintiffs are entitled to damages.

4. This litigation began on January 24, 1990, when the four named Plaintiffs, Tioga Pines Living Center, Inc., Communicare of Indiana, Inc. d/b/a American Village Retirement Community, Bloomington Convalescent Center, Inc. and Meadow Heights Nursing Center, Inc., d/b/a Lincoln Hills New Albany, filed a complaint alleging procedural and substantive claims relating to Indiana's system of Medicaid reimbursement for nursing homes set out in 470 IAC 5-4.1. The Court entered a preliminary injunction on May 29, 1990, and subsequently certified the action as a class. In October, 1990, 151 nursing homes intervened as named Plaintiffs, and the complaint was amended. By order dated September 25, 1990, the case was bifurcated for a trial on liability.

5. This case was brought as a class action under Indiana Trial Rule 23(B)(2) and (3). On May 29, 1990, this Court certified the plaintiff class as comprising long term care facilities licensed under I.C. 16-10-4, and which have been certified to provide care and services to Medicaid residents.

6. Defendant Indiana State Department of Public Welfare ("DPW") is the state agency responsible for administering Indiana's Medicaid reimbursement program. Defendant Indiana State Board of Public Welfare ("DPW Board") is created by In.C. 12-1-15-2, and is responsible under I.C. 12-1-2-2 for the adoption of rules governing DPW. Defendant Suzanne Magnant was the administrator, DPW, when this action was filed, and was sued in her capacity as administrator.

7. The amended complaint contained a procedural claim that a feature of the reimbursement system call the "test of reasonableness" had not been properly promulgated as a rule. On February 7, 1991, the Court granted partial summary judgment for the Plaintiffs on that the "test of reasonableness" was improperly and illegally promulgated.

8. The amended complaint also contained a claim that the Medicaid rates paid by the State under 470 IAC 5-4.1 violated the federal Boren Amendment, 42 U.S.C. 1396.

9. Plaintiffs principal federal law claims are that the Medicaid reimbursement rates paid by DPW to the class under the state Medicaid plan in effect since April 1, 1983, have not been:

> [R]easonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . . "

42 U.S.C. § 1396a(a)(13)(A) (Supp. 1988). In addition, the Plaintiffs claim that DPW failed to make proper "findings" at least annually since April, 1983 as required by applicable federal regulations.

10. Effective October 1, 1990, the Boren Amendment, was amended, and established a higher substantive payment standard, providing that states must provide payment to nursing facilities:

> [T]hrough the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, *take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident eligible for benefits under this subchapter* . . . which the State finds and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . .

42 U.S.C. § 1396a(a)(13)(A) (Supp. 1991) (emphasis added). This higher payment standard is currently in effect, and governs Plaintiffs' claims as of October 1, 1990.

11. Plaintiffs also claim that Medicaid reimbursement rates paid by DPW have violated state law, I.C. 12-1-7-17.6(B) (1990), which provides that rates:

> [S]hall, under 42 U.S.C. § 1396a(a)(13)(A), be determined in accordance with a prospective payment rate that is reasonable and adequate to meet the costs that are incurred by efficiently and economically operated facilities in order to provide care and services in conformity with State and Federal laws, rules, regulations, and quality and safety standards, with a growth or profit factor, as determined in accordance with generally accepted accounting principles . . .

Other state claims relating to DPW's use of unpromulgated and illegal rules were resolved in Plaintiffs' favor on summary judgment.

12. Effective June 14, 1991 I.C. 12-1-7-17.6(b) was amended, and now provides that payment for nursing home care:

> [S]hall under 42 U.S.C. 1396(a)(13)(A) be determined in accordance with a prospective payment rate that is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with State and Federal laws, rules, regulations, and quality and safety standards, in accordance with rules adopted by the state department.

P.L. 240-1991(SS2), § 17.6(b), 107th Gen. Assembly, H.E.A. No. 1001.

13. The amended complaint also included a federal procedural claim under 42 U.S.C. § 1983 that Defendants failed to make certain "findings" that the Medicaid reimbursement rates complied with the Boren Amendment. On February 7, 1991, the Court held that a two year statute of limitations barred all section 1983 claims accruing prior to January 24, 1988.

14. At issue at the trial was 470 IAC 5-4.1, the State's rate-setting methodology for Medicaid reimbursement to nursing homes, which was put into effect on April 1, 1983. This system was developed in 1983 by the Department of Public Welfare. The industry has received rates based on this methodology through the present date. Indiana's rate-setting methodology is prospective, which means reimbursement levels are based not on past costs, but on projected costs. In the Indiana system projected costs are based on *budget* submissions of the providers. Each provider submits an annual budget to Myers and Stauffer, the State's rate-setting contractor, requesting a level of reimbursement for the upcoming year. Myers and Stauffer makes adjustments to the budget requests to determine a final per diem rate.

15. First, certain cost limiters are applied to the budget requests, these are: the "test of reasonableness" which this Court has already determined to have been illegally promulgated; the owner, related party and management compensation limitations;

the owner's expense limitation; the staffing limitation. Capital costs included in the budget requests are placed with a "capital return factor", calculated for each facility based on a formula, which includes a use fee (debt service) component and a profit, or return on equity component. The resulting figure is labeled "budgeted allowable costs". This is essentially the providers' original budget requests adjusted by various limitations set forth in the State's plan and with actual capital costs replaced by the capital return factor.

16. The current Medicaid nursing home reimbursement system was developed in 1982 and 1983, and became effective April 1, 1983. The rate setting system is prospective, in that rates for a particular year are set in advance of the date that the services are provided. The rate-setting process begins when a facility submits its cost report to DPW. The cost report contains the facility's historical incurred costs for the year just ended, and the anticipated budgeted costs for the upcoming rate period. This date is input into a computer data base. Defendants' rate-setting contractor, Myers & Stauffer, Certified Public Accountants, is responsible for reviewing facility cost reports and for setting rates.

17. Myers & Stauffer makes various adjustments to a facility's budgeted costs. First, the rate setting removes any nonpatient related costs, and reclassifies costs which might have been misclassified. Then, the rate setter analyzes each line item budgeted cost, comparing each line item to the prior year's historical incurred cost plus an adjustment for inflation. This same procedure occurs a second time, and additional disallowances may be made when the rate setter analyzes the line systems aggregated by each cost center.

18. Next, the rate-setting compares each facility to other facilities in a peer group. If the facility's total budgeted costs (i.e., after the adjustments made in the two prior steps) exceed the 75th percentile, each cost center in excess of the 90th percentile

is further reduced to the 90th percentile. The various cost adjustments discussed above are referred to as the "test of reasonableness". This state of the rate-setting process is referred to as the "desk review".

19. From this point, the rate-setting software calculates each provider's rate. A "provider" is a designation relating to the level of care rendered in a nursing home "facility". There are three types of providers in Indiana: skilled (SNF); freestanding intermediate care (ICF—freestanding); and intermediate care of a dually-certified (skilled and intermediate) facility. The software performs a series of additional, automatic cost disallowances, which include:

a) removal of budgeted property costs of rent, interest and depreciation, and substitution of the Capital Return Factor;

b) application of the staffing limitation which disallows costs for hours worked in excess of a specified cap;

c) application of the related party limit;

d) application of the excess compensation to owners and management personnel limit; and

e) application of the limit on interest on working capital.

The result of the desk review and automatic cost disallowances is called the "budgeted allowable cost". This figure is divided by the greater of actual occupancy or an imputed occupancy of 80%, and is called the "per diem cost" or "patient day expense."

20. After all of the preceding cost disallowances have been made, the provider's patient day expense is compared to the Market Area Limitation ("MAL"). MALs are computed quarterly (March 1, June 1, September 1, December 1), and equal 140% of the weighted average provider cost for the particular provider classification. There are nine provider classifications, based upon provider type (skilled, intermediate or freestanding intermediate) and regional location (north, central, south). If the

provider's patient day expense is less than the applicable MAL, the provider is eligible to receive a fraction of the difference as a "profit factor" or "incentive for efficient operation". The patient day expense, plus any incentive, is the provider's calculated rate.

21. The nursing homes do not necessarily receive the calculated rate or any earned efficiency incentive. Instead, a provider will receive the *lowest* of five possible rates:

a) the rate the provider charges its private pay (non-Medicaid/Medicare) residents;

b) the rate the provider requests;

c) the applicable MAL;

d) the provider's calculated rate; or

e) the rate calculated in accordance with the maximum annual rate increase limitation.

22. The maximum annual rate increase provision limits the provider's rate to the *prior year's rate*, inflated by the twelve quarter rolling average of the Gross National Produce Implicit Price Deflator ("GNP/ipd"). A substantial majority of the providers (between 66% and 75% for 1987 through 1990) have had their rates capped by the maximum annual rate increase limitation.

23. The GNP/ipd is an economic index which measures inflation or the changes experienced by the economy from year to year. The index is based upon changes throughout the entire economy and does not focus specifically upon the sector of the economy involved with medical costs or nursing home costs.

24. The nursing home industry did not complain about the reimbursement scheme from its inception until 1987. According to Plaintiffs' witness William Hartung, who was in charge of the Medicaid program at the Department of Public Welfare for that period of time, the nursing home industry was "pretty happy" with its rates from September, 1985 through July, 1987.

25. The witnesses presented a variety of statistical analyses of the aggregate rates received by Indiana nursing homes.

26. This cases involves the question of the relationship between financial issues and the adequacy of the quality of resident care being provided to the citizens of Indiana in nursing homes. The evidence demonstrates that reimbursement rates are not reasonable and adequate to cover the costs facilities must incur to provide the care required to comply with prevailing quality of care requirements imposed upon nursing home owners and operators. Medicaid reimbursement rates have been unreasonable and inadequate at least since April, 1987; and, nursing homes have had substantial difficulty meeting federal and state quality of care requirements since mid-1987.

27. Plaintiffs' challenge focuses primarily on the annual limiter which limits rates to nursing homes' previous year's rate inflated by the 12-quarter moving average of the GNP/ipd index.

28. This court finds that from its inception in 1983, the Indiana reimbursement system was defectively designed, insofar as its principal features ignored a balanced approach to resolving the conflicting goals inherent in a Medicaid reimbursement system, by subordinating the issues of quality of care, increased access to quality services to all citizens and adequate capital formation, to an overriding desire for cost containment. The rate system contains various cost limiters, including the test of reasonableness and the staffing limit, and rate limiters, the most significant of which is the annual limiter.

29. In 1982, DPW was mandated by the legislature to investigate certain issues relative to the Medicaid reimbursement system which caused indefensibly undesirable effects: (1) disallowances of expenses for staff which were found to be disincentives to providing adequate staff for quality care; (2) aspects of computation of capital reimbursement which caused multiple changes of ownership and significant increases in Medicaid program costs without a corresponding improvement of

quality of care; and (3) an inflation index as a maximum annual rate limitation which was unrelated to costs actually incurred by the nursing homes.

30. Mr. Donald L. Blinzinger, the administrator of DPW, the sole agency responsible for administering the Indiana Medicaid program, testified that his department proposed changes to rectify those previously identified inadequacies within the pre-1983 system. Furthermore, Mr. Blinzinger testified that DPW recommended for approval as the maximum annual rate limitation an index which closely approximated projected medical cost increases nursing homes would incur. This index was unequivocally rejected and he was directed to use the GNP/ipd by the state budget agency. No analysis of how this index would impact on the remainder of the reimbursement system or the provision of quality services to the citizens of Indiana was ever done by any state agency, its staff or retained independent contractors prior to the installation of the index within the system. It was solely a budget driven cost containment device.

31. Economic indices such as the medical component of the consumer price index and the HCFA-SNF are indices that measure changes in prices specific to the medical sector of the economy. They reflect the prices of such items that typical costs of medical care or nursing care. Such indices are better measures of costs that are being incurred by nursing homes, than is the GNP/ipd.[1]

32. The so-called "test of reasonableness" is another cost containment device within the Indiana reimbursement system which results in substantial disallowances of provider costs.

33. The staffing cap, another one of the cost containment devices, is particularly inappropriate containment because it cuts right to the heart of a facility's ability to provide quality resident care. For the past five years, skilled and intermediate providers

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[1] The court is aware that in March of 1991 the defendant promulgated by new regulation a modified "annual rate limiter" which replaced the GNP/ipd with such an index; the HCFA SNF Market Basket.

have staffed in excess of the staffing reimbursement cap, thereby providing staff to fulfill the needs of their patients without reimbursement for the expenses incurred.

34. DPW's most persuasive cost containment weapon is the annual limitation on rate increases. The operation of the maximum annual rate increase limitation determines the rates for the overwhelming majority of facilities each year. By virtue of the manner of its imposition, and the fact that its components are unrelated to nursing home costs in Indiana, it is clear that the maximum annual rate limitation is driven only by Defendants' desire to contain program costs. To the extent that it does not reflect costs associated with nursing home care, it suffers the same indefensible defects DPW found with the prior rate increase cap in 1982.

35. The Indiana rate setting criteria do not limit the *costs* to be reimbursed to those that are incurred by efficient and economically operated facilities but rather establish a limitation primarily and progressively *based upon the prior year's rates* irrespective of the costs incurred.

36. For the last three years approximately 90% of the class of health facilities herein had their rates determined by the application of the gross national product implicit price deflator on their prior year's rate rather than based upon the budgeted costs submitted to the Defendants.

37. The operation of the Gross National Product Implicit Price Deflator ("GNP/ipd"), as a cap to annual rate increases since 1983, has created a "rate on rate" system. By virtue of this feature, over time, reimbursement rates in a particular year are being set based upon the rates that were allowed in previous years. With each year, for the high percentage of facilities which are capped by the GNP/ipd, the rates lag further and further behind the costs actually being incurred to provide care within that any rate effective period. This is a fundamental design defect in the system.

38. The fact that the GNP/ipd was chosen by the state budget agency in 1982 together with the fact that it so dominates the rate setting criteria that it in effect sets the rates for nearly two-thirds of the facilities, overwhelmingly demonstrates that the Indiana reimbursement system is essentially, if not entirely, budget driven.

39. Data comparing total per diem rates to actual per diem costs demonstrates a downward trend in reimbursement, particularly in the past several years. According to the evidence, the percentage of nursing homes which received rates below their actual costs has increased steadily over the last four rate effective years (April 1, 1986 to March 31, 1990):

| 1986/1987 | 1987/1988 | 1988/1989 | 1989/1990 |
|---|---|---|---|
| 41.2% | 53.2% | 60% | 70.6% |

40. For the average nursing home, in the rate effective year ending March 31, 1990, Medicaid reimbursement fell short of Medicaid costs incurred by $5.04 per patient day. This is not an isolated incident. Since 1986-87, the amount of this underpayment to the average indiana nursing home has grown substantially, further demonstrating system-wide defects in the reimbursement plan. These real losses to Indiana providers and the nursing home residents are substantial. Indiana long term care facility per diem costs, on average, exceeded the per diem reimbursement rates by the following amounts for the last four rate effective years:

| 1986/1987 | 1987/1988 | 1988/1989 | 1989/1990 |
|---|---|---|---|
| $0.63 | $1.01 | $2.43 | $5.04 |

41. When these per diem losses are multiplied by the number of Medicaid patients per year, the difference between rates paid and costs incurred is substantial. For the last four rate effective years, facility incurred costs have exceeded aggregate payment as follows (expressed in *millions* of dollars):

| 1986/1987 | 1987/1988 | 1988/1989 | 1989/1990 |
|---|---|---|---|
| $4.9 | $9.2 | $19.0 | $38.7 |

42. Based on historical patterns, the losses will continue to increase over time because Indiana's rate increases consistently fail to match nursing home cost inflation in the state. For example, the $38.7 million under-reimbursement to Indiana Medicaid providers in 1989/90 is almost seven times that of just three years before in 1986/87. Between 1987/88 and 1989/90, the amount of under-reimbursement doubled from $19 million to $38.7 million.

43. The Indiana criteria create a rate-on-rate system merely based upon the prior year's rate and not based upon costs incurred by efficient and economically operated facilities, The substance of this finding was not refuted by any of the witnesses.

44. Defendants' Exhibits 373-375 show the following percentages of providers statewide whose rates *did not* cover 100% of their costs incurred to provide services to Medicaid residents:

| 1987/1988 | 1988/1989 | 1989/1990 |
|---|---|---|
| 47.64% | 53.26% | 62.95% |

45. The State Budget Agency ordered the gross national product implicit price deflator to be used as the overall rate limiter without any studies whatsoever being done to justify its use. This was done for budgetary reasons only and the limiter had no direct relation to costs incurred by efficient and economically operated facilities.

46. Health facility costs have been rising at rates between 6% to 15% per annum but the gross national product implicit price deflator has been raising at the rate of 2.8% to 4.0% per annum. With costs rising at 6% to 15% per annum and rates increases capped at only 2.8% to 4.0%, it does not take long before facilities cannot cover the costs incurred to render quality care to Medicaid patients with the reimbursement paid in accordance with the regulations. The system results in reimbursement rates that are not reasonable and adequate to reimburse facility costs.

47. Well in excess of 70% of the facilities in this state are not being reimbursed their costs and rates in many instances are substantially below costs that are being incurred to attempt to render quality care.

48. Defendants Exhibits 370-375 (covering the rate effective years ending 1988-1990) also contain three other "alternative" comparisons of provider costs and rates.

49. Alternatives 2 and 4 compare provider per diem rates to less than total per diem historical costs. Costs of building depreciation, "excess" compensation to owners, related parties and management personnel (determined in accordance with the reimbursement relations) were removed from the actual per diem cost. Alternatives 3 and 4 exclude from the analysis altogether any providers with occupancy below 80%. These documents also show the percentages of providers that receive rates covering less than 100% of their costs (e.g., the percentage of providers that receive 985 of cost, down to 85% of cost).

50. Defendants' expert, Gretchen Engquist's assertion that depreciation is "not a true cost" is rejected inasmuch as she is neither an accountant nor an economist and therefore has no expertise in the area of cost accounting. Surely the purchaser of a facility considers depreciation a true cost, which is the allocation of the purchase price over the useful life of the asset. Moreover, Defendants removed depreciation costs from the cost side, *without* making a corresponding adjustment to the rate side of the comparison—that is, removal of the payment under the capital return factor paid *in lieu* of property costs, specifically depreciation. Consequently, their cost versus rate comparison obviously skews the equation in favor of the system.

51. Defendants performed *no* study of available cost data to support the exclusion of all depreciation costs—even those costs incurred by Indiana facilities that might be efficient and economical. The lack of a reasonable factual basis for excluding all depreciation costs is another basis for rejecting the analysis as unreasonable and skewed in favor of the system.

52. The exclusion of providers with less than 80% occupancy is completely arbitrary. There is no evidence justifying this standard. There is no evidence showing that studies were performed by DPW relating to the Indiana nursing home industry, and the number of available licensed beds actually in service on a consistent basis in the state. As far as Ms. Engquist was aware, Defendants selected the 80% occupancy criterion without making a finding as to its validity in Indiana. She also testified that the 80% occupancy standard is not a measure of efficiency or economy. Indeed, there is no evidence showing why 80% (versus some less or greater percentage) was selected. It was simply adopted without any examination of whether it was reasonable in Indiana.

53. There may be valid reasons why certain Indiana facilities have occupancy below the chosen percentage. While 80% occupancy might be a reasonable goal for some Indiana facilities but not others, due to relevant factors like size, rural location, etc., DPW simply took no steps to investigate the occupancy issue. DPW made no effort when it set payment rates to determine whether 80% occupancy, or some other standard was reasonable, in light of unique conditions in Indiana.

54. Common sense reflects that various factors might justify a variety of occupancy rates. For example, in Indiana's rural areas, a community may need a nursing home to care for the frail elderly, but there may be too few citizens in need to fill all available beds. Thus, a lower occupancy level is clearly justified in order to care for all Indiana citizens in need. In other areas, the state may elect to approve new construction when occupancy is below 80% to promote competition, to assure that patients in hospitals can be speedily discharged to less costly nursing homes, or that difficult patients have access to nursing homes. Yet, there is no evidence whether DPW considered these or any other relevant factors.

55. The occupancy issue is of minimal significance. Low occupancy, according to Ms. Engquist, impairs a facility's ability to spread only its *fixed* costs, thereby resulting in a higher per diem fixed cost component. Variable costs, however, can be managed

to achieve greater efficiency in light of existing occupancy. It was unreasonable to exclude as "inefficient" all facilities with occupancy below 80%—even those that were "efficient" when all costs were examined on a per diem basis.

56. The "low occupancy equals low efficiency" argument is rejected by the court.

57. For several reasons, this Court rejects Alternatives 2, 3, and 4 and the data showing the percentage of providers receiving less than 100% of their actual costs, in its evaluation of the adequacy of payment rates. It does so not only because of other evidence presented, but also, because of its assessment of the demeanor and credibility of the Defendants' witnesses. To determine whether the methods and standards within the rate-setting criteria reimburse for costs incurred by economically and efficiently operated facilities, one should compare rates to the total allowable costs as defined by the state plan *without limiting* those costs by other provisions in the state plan which purport to define implicitly efficient and economic costs. To do otherwise is an exercise in circular reasoning. It amounts to asking this Court to draw the conclusion that Indiana's rates are reasonable and adequate to cover costs which must be incurred by economic and efficient facilities because they cover that portion of those costs which the system *itself* defines as economic and efficient. This analysis proceeds from the implied proposition that the system itself is valid. It is a meaningless comparison to test the validity of the system. This comparison does not enable the Court to ascertain whether the rates are reasonable and adequate in real life. For the same reasons, this Court rejects any substantial reliance upon Myers & Stauffer's "prospective" analyses, which compare rates to budgeted allowable costs, although in those studies Defendants also found that many facilities received a rate lower than that which Myers & Stauffer's calculated they should have received.

58. HCFA and other courts have endorsed the comparison of total costs and rates. Similarly, HCFA and the courts have examined the percentage of facilities that received rates covering 100% of their actual costs.

59. The appropriate analysis is a comparison of the rate to total allowable costs without applying the adjustments found in the rate-setting criteria.

60. Mr. Buoy admitted in his testimony that Defendants' Exhibits 373, 374 and 375, which reflect the multiple alternatives and evaluations of providers receiving less than 100% of their costs for fiscal years ending 1988, 1989, and 1990, were prepared in the summer of 1990, nearly nine months after this lawsuit was filed. Because these documents were prepared months after this case began, and in some cases years after the rate periods they were designed to support, Mr. Buoy's testimony that the documents represent the continuation of the findings process for 1988, 1989 and 1990 squarely and inexplicably conflicts with Ms. Magnant's testimony. The state's attempt to justify this analysis is simply not credible. Not only does the new analysis presented by Mr. Buoy represent a fundamental change in how DPW evaluates the adequacy of rates, which happens to coincide with the significant rise in the percentage of facilities not receiving rates covering costs to a level over 50% in 1988, but also this Court finds that these documents were not part of the administrative record that existed when the rates were set. As such, they are post hoc rationalizations for the past rate-setting decisions.

61. It is clear from the evidence that Myers & Stauffer, and Mr. Buoy, particularly, took steps to hide from the Plaintiffs the date on which Defendants' Exhibits 373, 374 and 375 were prepared. These documents bear no "run date" showing when they were prepared. Similarly, in preparing previous reports concerning cost/rate comparisons for 1988, 1989 and 1990, Mr. Buoy instructed Myers & Stauffer personnel to *remove* the run date from the reports. Mr. Buoy's explanation for this action was not credible. Based on this troubling evidence, the Court finds Mr. Buoy to be clearly biased in favor of the Defendants.

62. It is evident that many if not most of the features of the system are overridden by the GNP/ipd. For example, the fact that rate-setting begins with a facility budget request is meaningless in two-thirds to three-fourths of rate cases in which the rate is set by the operation of the annual rate limiter irrespective of the budget request. The GNP/ipd sets the current rate based on the prior year's rate. A facility can budget all the increases it wants, or needs, but the maximum annual rate limitation will only pay that limited percentage of the needed increase that remains after the application of the limiter.

63. Defendants presented one expert witness who testified regarding the adequacy of reimbursement rates. Gretchen Engquist's testimony, on balance, was not credible, and does not support her conclusion that rates comply with federal and state law. Ms. Engquist's testimony is suspect for several reasons.

64. Ms. Engquist is neither an economist nor an accountant, and has no background in the field of quality of care. Ms. Engquist's education is in the field of psychology, with an emphasis on statistics. This Court gives little weight to her testimony as to whether Indiana rates are reasonable and adequate to meet the costs of providing quality resident care.

65. Although Ms. Engquist has worked with matters relating to Medicaid reimbursement, almost exclusively on behalf of state agencies, her experience as Medicaid director in the state of Missouri in the early 1980's calls her competence and credibility into serious question:

a) In 1983, Ms. Engquist served as director of the Missouri Medicaid program. As such, her responsibilities included ensuring that nursing home rates were sufficient to cover the costs of providing adequate care to residents. In 1983, with Ms. Engquist's input and supervision, the Medicaid agency attempted to change the reimbursement system. Ms. Engquist subsequently became a defendant in litigation challenging the proposed reimbursement system.

b) In that case *Bolivar Nursing Home v. Missouri Dep't of Social Servs.*, the trial court made several findings that Ms. Engquist's agency acted unlawfully. *See* Plaintiffs' Exhibit 40. For example, the court found that Ms. Engquist's agency:

> [M]ade no valid attempt to ascertain whether the final rates assigned a provider were sufficient to reimburse for the level of care needed by that provider's residents or to ascertain the relation of providing that level of care to actual allowable costs of such care. Defendants have attempted to isolate the cost of operating a nursing home from the cost of providing adequate patient care. The two are intertwined and must be evaluated together.

c) Ultimately, the court found that the proposed plan amendment violated state law and the Boren Amendment standard which Defendants urged the court to apply.

66. The evaluations Ms. Engquist performed do not support her conclusion that payment rates are reasonable and adequate. This Court rejects Ms. Engquist's opinions, insofar as they are predicated upon irrelevant comparisons between costs and rates in Indiana, versus costs and rates in other states. Similarly, Ms. Engquist relied upon Myers & Stauffer's alternative comparisons of rates to less than full actual incurred costs—comparisons which this Court has rejected as having no relevance to a proper assessment of the adequacy of reimbursement rates.

67. Ms. Engquist's reliance on comparisons of Indiana rates to less than 100% of actual costs, and to budgeted allowable costs, reflects circular reasoning. Such analyses are tantamount to comparing the costs which the system reimburses to what the state actually pays in order to determine whether the rates paid pursuant to the system are adequate and lawful.

68. This Court also received substantial evidence demonstrating that Indiana nursing homes have had significant difficulty complying with prevailing quality of care requirements. Jean E. Johnson, M.S.N., NP-C, in the area of gerontological nursing, testified concerning the quality of care. Ms. Johnson's evaluation of statistical data regarding quality of care credibly demonstrated the significant difficulty nursing homes have had in complying with prevailing quality and safety standards. The evidence relating to quality of care covered the same time period (mid-1987 through late 1990) in which over one-half of all facilities in Indiana received rates that were below actual costs.

69. The inability to cover costs with the reimbursement paid pursuant to the regulations coincides with an increase in the number of citations for deficiencies in quality of care in facilities as well as an increase in the number of decertification and licensure actions since 1987. The Court infers from this coincidence that quality of Medicaid patient care is declining due to inadequate rates caused by the Indiana rate setting criteria.

70. DPW currently limits recognition of nursing home staffing costs to a maximum of 4.75 hours per patient day for a skilled nursing facility (SNF) and 3.75 hours per patient day for an intermediate care facility (ICF). Until August 8, 1988, SNFs were subject to a cost recognition cap of 4.5 hours per patient day and ICFs were limited at 3.5 hours per patient day. these limitations are absolute across-the-board ceilings determined without regard to the circumstances of any specific nursing home, or the whole industry, and without regard to whether higher staffing is necessary to meet patient needs.

71. The financial impact of the staffing limitation is substantial. Over the last five rate effective years, members of the class and intervenors have spent over $70 million for staff to provide services to the residents of their nursing homes for which *no*

reimbursement was paid by the state. The amount of facility staffing costs disallowed over the last five years is as follows (expressed in *millions* of dollars):

| 1985/1986 | 1986/1987 | 1987/1988 | 1988/1989 | 1989/1990 |
|---|---|---|---|---|
| $11.1 | $12.4 | $19.9 | $12.5 | $16.2 |

This has perpetuated in an ever increasing manner a disincentive to provide quality services.[2]

72. The outcomes of annual nursing home inspections performed by the Indiana State Board of Health between July, 1987 and July, 1988 as complied in HCFA documents called Table 8, Table 10 and OSCAR, are representative of the significant difficulties Indiana nursing homes have had in complying with federal standards relating primarily to nursing care for the past several years.

73. For federal certification surveys conducted during the period July 1987 to July, 1988, 10% of skilled nursing facilities failed to comply with the condition of participation for nursing services. Accordingly, each of these facilities was subject to decertification from the Medicare and Medicaid programs if the problems were not corrected within three weeks. Nearly one-half of the facilities, 46%, did not meet the standard for prescribed treatments, medications and diets. Over one-third of the facilities, 34%, violated the standard requiring effective skin care. 16% had deficiencies regarding the treatment of decubitus ulcers. 37% of facilities were found to have improperly used restraints. 32% of the facilities did not meet the standard of care for incontinent residents. 85% were out of compliance with infection control requirements. This 85% figure translates into approximately 27,000 nursing home beds, which are at least 80% occupied. Thus, approximately 21,500 residents were exposed to the detrimental effects of poor infection control.

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[2] While these disallowances were proven by the evidence, it is unclear whether these damages are subsumed into the loss occasioned by the operation of the GNP/ipd and the "tests of reasonableness".

74. The data for intermediate care facilities for the same period were equally stark: 36% of the facilities surveyed did not give prescribed treatments, medications and diets as ordered. 42% of the facilities were cited for not providing personal hygiene services are required. 22% were found in violation of the standard for proper skin care. 29% were cited for improper use of restraints.

75. Ms. Johnson concluded that skilled and intermediate care facilities are having significant problems meeting quality of care requirements.

76. The significant level of facility noncompliance reflects the interplay between economics and a trend in resident dependence and care needs. Nursing home residents are sicker and more dependent than in previous years. The increase in dependence translates into the need for more staff with greater nursing skills. Significant features of the payment system, like the arbitrary cap on staffing-related reimbursement, and the maximum annual rate increase limitation, strongly influence how well facilities are staffed. The inability of Indiana facilities to meet prevailing quality of care requirements relates to inadequate staffing levels. Obviously, increased staffing translates into higher costs. For the past five years, facilities have been staffing in excess of the reimbursement cap, at a significant financial loss.

77. Robert Goodnow, director of the Bureau of Quality Assurance at the Indiana State Board of Health, testified at length about how surveys are performed, and how compliance determinations are made. Although Mr. Goodnow is not a health care professional, has never personally performed a nursing home survey in this state, and is not an expert in quality care in Indiana nursing homes, he testified that the survey data reflected in the HCFA compilations contained unacceptable levels of noncompliance. Remarkably, he also stated that the high rate of deficiencies were not, in his opinion, indicative of poor quality. It is difficult for this Court to reconcile this testimony.

78. Since mid-1987, nursing home compliance has been at levels that Robert Goodnow, Director, Bureau of Quality Assurance, Indiana State Board of Health, deemed "unacceptable". Mr. Goodnow admitted that the number of facility deficiencies cited for noncompliance with prevailing federal standards has increased since 1986. The uncontroverted evidence proves that Indiana nursing homes have had unacceptable levels of noncompliance with federal certification standards.

79. The high levels of noncompliance are in areas directly relating to the quality of nursing care being provided to the people residing in Indiana nursing homes. For example, federal certification surveys performed by the Indiana State Board of Health in the year ending July 1, 1988, show that residents in skilled nursing facilities were receiving substandard care in critical care areas:

| Area of Deficiency | Percentage of Facilities Found Out of Compliance with Federal Certification Standards | Approximate Number of Residents Potentially Affected[3] |
|---|---|---|
| Infection Control . . . | 85% | 21,600 |
| Personal Hygiene . . . | 57% | 15,350 |
| Prescribed Treatments, Medications and Diets . . . . . | 46% | 12,950 |
| Use of Restraints . . . | 37% | 9,620 |
| Skin Care (to prevent decubitus ulcers) . . . . . | 34% | 9,560 |
| Care of Incontinent Residents . . . . . | 32% | 8,820 |
| Treatment of Decubitus Ulcers . . | 16% | 4,690 |

[3] These figures conservatively assume a facility has residents in 80% of the available beds.

To argue that these care areas, and the numerous other areas with high deficiency levels, have nothing to do with quality of care, as Defendants suggest, is beyond the pale. Clearly, the residents and their families do not consider these types of deficiencies unimportant technicalities. Likewise, the fact that Indiana nursing homes staff well above the level that the state pays for demonstrates that nursing homes do not consider these citations unimportant.

80. If one examines the Board of Health's compilation of adverse decertification actions (i.e., to terminate participation in Medicare or Medicaid), the same troubling picture emerges. From 1986 through 1990, the Board of Health initiated adverse actions against facilities at an unacceptable level. According to Mr. Goodnow, the following numbers of facilities were the subjects of actions to terminate their participation in the Medicare and/or Medicaid programs:

| Year | Adverse Actions |
|---|---|
| 1986 | 68 |
| 1987 | 72 |
| 1988 | 72 |
| 1989 | 68 |
| 1990 | 67 |

Thus, since 1986—precisely the period when the evidence shows payment rates were unreasonable—approximately 12% of Indiana facilities have been subject year in and year out to termination from Medicare or Medicaid programs.[4] Certainly the administration, staff and patients in these facilities did not consider termination from Medicare or Medicaid programs a matter of technical compliance. These termination actions reflect a determination that the quality of care is so deficient that Medicare

[4] This figure includes no adjustment to account for new facilities or those that changed ownership. Of course, such facilities receive rates that are not subject to the most onerous limiter for a period of 18 to 22 months, and therefore do not have the same difficulty satisfying the costs of compliance. If such an adjustment were made it is reasonable to expect that the percentage of adverse actions would increase.

or Medicaid patients should be forced to relocate and that the nursing home should no longer be eligible for program payments unless conditions are corrected within 45 to 90 days.

81. The frequency of "fast track" decertification, where the Board of Health finds a "serious and immediate threat" to facility residents, is even more alarming. A finding of serious and immediate jeopardy means that state inspectors believe that "the threat of probable harm is real and important and could be perceived as something which will result in potentially severe temporary or permanent injury, disability or death." The problems must be so serious that the nursing home's participation in Medicare and Medicaid can be terminated—and all its program patients forced to relocate—in less than 23 days.

82. Since 1986 Indiana nursing homes have been subject to sharply increasing fast track decertification actions:

| Year | "Fast Track" Decertification Initiated |
|---|---|
| 1986 | 1 |
| 1987 | 4 |
| 1988 | 8 |
| 1989 | 18 |
| 1990 | 15 |

See Defendants' Exhibit 37. the Board of Health has found "serious and immediate" threats to residents with increasing frequency over the years. Mr. Goodnow's inexpert and subjective conclusion that quality of care overall has improved, has no basis in fact.

83. Ms. Engquist's comparison of rates to an arbitrary fraction of actual incurred costs appears to be contrary to the intent of Congress, as expressed in the House Budget Committee report supporting the Omnibus Budget Reconciliation Act of 1987 ("OBRA '87"), which amended the Boren Amendment effective October 1, 1990.

84. Congress was explicit in demanding the nursing homes be reimbursed by Medicaid for the *costs* of meeting the new

OBRA '87 care requirements. Moreover, the legislative history corroborates the existing Boren Amendment command that payment rates be adequate *to permit facilities to meet all quality of care standards*. The House Budget Committee report states:

> The Committee recognizes that quality care is not free. A number of these requirements will entail additional costs of operation for nursing facilities participating in Medicaid. the Committee amendment would therefore require that, with respect to complying facilities, State Medicaid payment rates take into account the costs of complying with the requirements relating to provision of services, residents' rights, and administration.
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> • • •
>
> The Committee amendment would mandate significant additional requirements for many state Medicaid nursing home programs. It is the intent of the Committee that the States' Medicaid programs provide for an adjustment (in their Medicaid plan) and make payment commensurate to the cost incurred by the providers in implementing the new requirements and that such payment be made as those costs are incurred.

H.R. Rep. No. 391(I), 100th Cong., 1st Sess. 463-64 (1987), *reprinted in* 1987 U.S. Code Cong. & Admin. News 2313-283 through 2313-284. The House Budget Committee report also indicates that state Medicaid plan amendments are required to "assure that State payment rates actually take into account the costs of complying with the new requirements."

85. This Court finds an unacceptably high level of difficulty in compliance has existed for the past several years, and also finds that this noncompliance raises serious questions about the quality of nursing home care. The Court also finds that the state has never formally determined, as it is required by law to do, whether the lack of Medicaid reimbursement has been a cause of facility noncompliance. The Court finds the lack of reliable

method of communicating about the quality of care in Indiana nursing homes and costs to be a fundamental violation of the duty of the state government to its citizens.

86. The primary way in which a facility can escape the annual rate increase limitation is through change of ownership. New owners are given a "restart"—a new rate not capped by the GNP/ipd. This event, however, increases the costs to the Medicaid program without necessarily improving care. This was one of the indefensible defects noted in 1982 by DPW. It has resurfaced within the present system over the years. The unusually high number of ownership changes corroborates this Court's finding that the DPW system is defective, budget driven and incapable of directly reimbursing homes for costs actually incurred in providing adequate care.

87. Defendants claim that a change of ownership, where one facility goes out of business and a "prudent businessman" enters the industry, supports a conclusion that the industry is financially sound and therefore also supports the inference that reimbursement is adequate. But for every prudent businessman coming into the system there is another prudent businessman abandoning the system. Defendants' own expert, Ms. Engquist, agreed that the frequent changes of ownership are a "very serious problem" in Indiana, and that it is "not very good reimbursement policy" for a payment system to encourage changes of ownership.

88. The high percentages of facilities receiving rates that do not cover their costs strongly suggests that financial distress is resulting in changes of ownership. Thus, the payment system is to blame. Ms. Engquist testified that the payment system encourages facility sales. This is because new providers have their rates set based on their budgeted costs, and their rates are not limited by the GNP/ipd for a period approximating the first 22 months of operation. Keenan Buoy, of Myers & Stauffer, the state's rate-setter, agreed change of ownership is a means to escape the effect of the GNP/ipd rate limiter. The system has driven hundreds of providers out of business.

89. As for new nursing home construction, no evidence was presented as to how many facilities were built, when they were built, or whether the unidentified facilities even participated in the Medicaid program. Nonspecific testimony about new construction—without factual support—is not a reasonable basis for this Court to conclude that DPW's rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities.

90. The Court rejects the asserted inference that the rates were adequate because the industry experienced a number of sales of facilities. The Court rejects this inference because details of such sales were not established nor was any evidence presented as to rate of return facility owners obtained either before or after the sales. In fact, the more reasonable inference is that the use of the gross national product implicit price deflator as a rate limiter has encouraged, if not caused, the numerous sales which have occurred in this state. The evidence established that a facility's rate will increase to allow a new owner to be paid its reasonable budgeted requested costs for a period of approximately twenty-two (22) months following a change of ownership. Thus, with no change in personnel or services the sale of a facility causes the rate to increase to reimburse costs incurred merely by the fact of the change of ownership itself. Sales are most likely occurring because of a need for a seller to get out from under inadequate rates set by the annual limiter, and the ability of a buyer to avoid the cumulative effect of the past application of the annual limiter. The seller must sell because his reimbursement rate at the time of sale is inadequate to cover costs; the buyer can buy because *his* rate is a new rate which *is* based upon costs and, for at least 22 months, not effected by the annual limiter.

91. It was also asserted that facilities in this state are inefficient and uneconomical in their operation. No reliable evidence was presented in the record to establish this. The state has not specifically defined what it considers to be an efficient and economically operated facility in its regulations. While the Defendants attempt to argue that the criteria itself establishes efficiency

and economy, the Court notes that the Defendants' witnesses rejected the suggestion that the costs of an efficiently and economically operated facility should be those costs determined after all cost containing measures contained in the regulations were utilized. The Defendants instead asserted that only the final rate determines the costs of an economic and efficiently operated facility but, as this Court has previously found and noted, the rates are set by the gross national product implicit price deflator change and are not based upon costs being incurred by facilities. The Court thus rejects Defendants' assertions in this regard.

92. The adequacy of Medicaid payments is necessarily intertwined with the issue of whether Defendants made the principled and reasoned analysis of the adequacy of rates in relation to compliance with quality of care standards—so-called findings—at least annually since the plan was adopted in April, 1983. The Court concludes, as a matter of fact, that Defendants never made proper and timely findings.

93. Two individuals served as administrator of DPW since April, 1983: Donald L. Blinzinger and defendant Suzanne Magnant. Both testified in this case as to the issue of findings.

94. Mr. Blinzinger, who was responsible for the adoption in 1983 of the current reimbursement system and served as head of the state Medicaid agency until June, 1988, testified at length. He had the responsibility for ensuring that proper and timely evaluations of the rates and compliance with quality of care standards were made. Plaintiffs proved that no principled analysis was ever done or documented.

95. First, Mr. Blinzinger testified that while he was administrator of DPW, he was never presented with any agency documents that were identified as documentation supporting findings. Second, whatever data compilations had been prepared by Myers & Stauffer since 1985, the proof is clear that no DPW official, neither Mr. Blinzinger nor his successor, ever specifically analyzed the relationship between the rates and compliance with

quality of care standards in any principled or objective way. Third, Mr. Blinzinger had virtually no knowledge regarding the level of facility noncompliance with prevailing quality of care standards. And most critically, the proof is overwhelming that DPW did not conduct any annual formal principled evaluation that rates were reasonable and adequate, in light of facility compliance with quality standards.

96. Ms. Suzanne Magnant succeeded Mr. Blinzinger as administrator of DPW in June, 1988. Ms. Magnant also failed to ensure that DPW made proper and timely findings. Just as during Mr. Blinzinger's tenure, Ms. Magnant admitted that there is no written record reflecting that she ever reviewed any cost/rate comparisons covering 1988 through 1990. Indeed, Ms. Magnant had no recollection of what if any documents she might have relied upon in making findings in 1988 and 1989. Likewise, she had no knowledge of whether she examined nursing home quality survey documents.

97. The absence of any documentation reflecting an analysis of relevant factors by DPW leaves precious little for this Court to review.

98. It is evident that DPW did not identify and determine the characteristics of efficiently and economically operated facilities, in terms of the costs they must incur to provide quality care. There is no evidence showing that DPW even thought about the issue, let alone performed the required analyses. Nothing in the record shows that DPW examined the impact of the "test of reasonableness", the staffing limitation, the Capital Return Factor, and the maximum annual rate increase limitation, on the payment of costs incurred by efficiently and economically operated facilities in relation to compliance issues.

99. This Court does not accept Donald Blinzinger's and Suzanne Magnant's testimony that they made findings at least each year since 1983. Leaving aside the question of the adequacy of the information they claim to have considered, there is no evidence corroborating their testimony that DPW in fact made a

finding each year. There is not a single document in evidence that shows that any DPW official, let alone Blinzinger and Magnant, ever reached a conclusion that annually since 1983 rates continued to meet the Boren Amendment standard.

100. Defendants presented to this Court literally hundreds of documents, but not a single one shows that DPW officials ever determined annually that rates continued to meet the Boren Amendment standard. HCFA requires state Medicaid agencies to maintain documentation supporting findings, so that "HCFA may request additional background information . . . and appropriate data would be made available as needed." 48 Fed. Reg. 56050 (1983). Furthermore, HCFA stated that the Medicaid regulations "require the state agency to maintain records . . . [and make them] available to individuals and providers who request them". *Id.* at 56051. The purpose was to "adequately assure public disclosure of States' findings." *Id.*

101. If there was documentation supporting agency findings for 1988 through 1990, prepared *before* the findings were allegedly made, surely Defendants would have presented it to this Court. There is not a single document in evidence reflecting that Ms. Magnant or Mr. Blinzinger ever saw, let alone analyzed in a reasonably principled manner, any information produced by Myers & Stauffer for any year since 1983. It strains credulity that DPW could have undertaken the necessary analysis and made a finding each year that rates were adequate without generating a single piece of paper that would inform this Court of exactly when the findings were made, what information was considered, what conclusion DPW reached, and why. Essentially, Defendants ask this Court to take it on faith that the required findings were made. Defendants have not earned the Court's faith in this case.

102. Reasonable professional people do not analyze the adequacy of a medical assistance program involving hundreds of millions of dollars, and the well-being of poor and disabled citizens, without any written documentation. A principled analysis

applying objective standards cannot be done without documentation each and every year. What this Court received was a raft of paper generated in response to a lawsuit. It is not contemporaneous documentation supporting annual findings, as is required by law.

103. There is no evidence that Blinzinger, Magnant, or some other agency official ever considered each year whether the staffing cap was reasonable, in light of available evidence that facilities on average staffed above the cap. Nor is there evidence that DPW considered each year whether the staffing cap was adversely affecting facility compliance. Available information would have shown DPW that facility compliance was a problem particularly in the nursing care area, and that facilities were incurring substantial losses in order to provide necessary staffing.

104. Similarly, there is no evidence that DPW considered each year the available information showing that the GNP/ipd was responsible for determining rates in the vast majority of cases. Further, there is no evidence that DPW considered each year the available data showing an obvious and increasing trend in the percentage of facilities that were being reimbursed less than their actual costs, their budgeted allowable costs, or some other adjusted cost figure. Defendants' Exhibits 367-375. Indeed, there is no way to tell what, *if any,* cost versus rate comparisons Blinzinger and Magnant examined in support of the annual findings. (It is clear that Ms. Magnant could not have considered in 1988 and 1989 those documents Myers & Stauffer prepared in the summer of 1990 after suit was filed.)

105. It is evident, from all of the evidence, that DPW officials never developed an "Objective benchmark" against which to measure whether the state plan resulted in reasonable and adequate rates. There was absolutely no examination of whether the cost disallowances made under the state plan were reasonable. DPW had nothing, and currently has nothing, against which to compare the state plan.

106. Accordingly, this Court finds that Defendants did not, at least annually, undertake a reasoned, principled, and objective analysis of all factors relevant to matters of reimbursement rates, costs, and compliance with quality of care standards.

107. The Defendants have previously calculated the damages caused by the use of the gross national produce implicit price deflator annual limiter and the test of reasonableness which was previously held to be illegally promulgated. The Defendants have submitted financial impact statements indicating annual damages to class members of $48,360,266; $32,883,538 caused by application of the gross national produce implicit price deflator and $15,476,728 caused by the test of reasonableness. The Court finds these figures to determine the rate that damages have been sustained by facilities from the date of the preliminary injunction, May 29, 1990, through March 29, 1991. Because damages accrued for a period of 10 months, the Plaintiffs are entitled to ten twelfths of that figure, $40,300,317, as compensation for losses accruing from May 29, 1990 to March 29, 1991.

108. The Defendants have accepted the concept that the aggregate extent of damages incurred is a mathematical calculation which can be made from information within the LTCIS (the long term care information system which is the acronym for the computerized system by which the State collects and preserves information from which the reimbursement rates are determined).

109. The information available in the LTCIS is sufficient for damages resulting from the application of the tests of reasonableness and the annual rate limiter to be calculated for all periods commencing January 24, 1988 through May 29, 1990.

110. The operation of the illegal Medicaid reimbursement regulations has also resulted in compensable injuries for the period January 24, 1988 to May 29, 1990.[5] The Court finds that

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[5] As is set out herein, the Court concludes that the applicable statute of limitations is 2 years and that the plaintiff's claims for damages accruing prior to January 24, 1988 are barred.

the computation of the total amount of damage caused during that period is susceptible to a straight forward mathematical calculation identical in form to that performed by the Defendants in June of 1990 for the period of time commencing May 29, 1990.

111. The distribution of damages to the members of the class, like the computation of damages, is a matter of straight forward mathematical calculation and properly the function of a master appointed pursuant to the provisions of Trial Rule 53.

112. This Court has found that the Defendants have not proven their defense that the members of the class should be barred from recovery because, in the aggregate, they have not operated their homes in an economic and efficient manner. The Court finds that to the extent the Defendants wish to raise any specific claim of inefficiency or lack of economy, such can be presented to the Master as a portion of the claim process.

113. Myron Bradburn or his corporations own and operate 16 facilities in Indiana and are Plaintiffs in a lawsuit in Blackford County Circuit Court entitled *Community Care Center, Inc.* v. *Indiana State Board of Public Welfare,* No. 05CO1-8808-CP-085. An injunction issued by the Blackford County Circuit Court in a partial summary judgment required the Department of Public Welfare to pay the calculated rate to the facilities owned by Bradburn or his corporations. The Department has not appealed the judgment, and has been paying these homes their calculated rates.

## ADVISORY CONCLUSIONS OF LAW

1. This cause of action was commenced on January 24, 1990 by way of a complaint filed on behalf of the plaintiff class against the Defendants. The complaint alleged that the plaintiff class was entitled to a preliminary and permanent injunction against the Defendants, a declaration that Medicaid reimbursement rate

regulations were illegal and invalid, for damages which have been incurred by the Plaintiffs as a result of the illegal and invalid regulations and for attorney fees.

2. On May 29, 1990, this Court entered a preliminary injunction in favor of the Plaintiffs and prohibiting the Defendants from continuing to rely upon the subject regulations to determine the rate of reimbursement to be paid to the plaintiff class.

3. On March 29, 1991, during the pendency of this action, the Defendants rendered the Plaintiffs' claims for injunctive relief moot by repealing the regulations which are the subject of this lawsuit and which were the subject of the trial which commenced February 19, 1991.

4. The repeal of the subject regulation has mooted all of the Plaintiffs' claims for declaratory and injunctive relief. Remaining are the claims set forth as paragraphs 5, 6, 7 and 9 of the Plaintiffs' amended complaint:

> "5. For an award of attorneys' fees pursuant to 42 U.S.C. § 1988 and TR 23(D), Indiana Rules of Procedure.
>
> 6. For damages to be measured by the difference between the Medicaid rates of reimbursement which should have been paid to the Plaintiffs and the class and the amounts actually paid as a result of the Defendants' illegal and improper application of unpromulgated rules against the Plaintiffs and the class both prospectively and retroactively.
>
> 7. For damages as measured by the difference between the Medicaid rates that were in fact paid to class members from April 1, 1983, to the date of a judgment herein, and the reasonable and adequate rates of reimbursement that meet the costs which must be incurred by efficiently and economically operated facilities, as required by I.C. 12-1-17.6-(b) and 42 U.S.C. § 1396(a)(13)(A), whichever is greater.

9. All other relief just and proper in the premises."

5. It is concluded that the applicable statute of limitations with respect to the Plaintiffs' claims for damages is two years. Therefore, all claims for damages which accrued before January 24, 1988 are barred.

6. This Court has jurisdiction over this action under 42 U.S.C. § 1396a(a)(13)(A), 42 U.S.C. § 1983, the Indiana State Plan Under Title XIX of the Social Security Act Medicaid Assistance Program (effective April 1, 1983, and as subsequently amended, codified as 470 IAC 5-4.1 et. seq.), the Indiana Declaratory Judgment Act, I.C. 12-1-7-17.7(B) (1990), and the provider contracts between the facilities and DPW.

7. This case has been previously certified as a class action pursuant to Trial Rule 23, and specifically Trial Rule 23(B)(2) and 23(B)(3).

8. In reviewing Defendants' actions in this case, this Court must determine whether Defendants have met the specific requirements of federal law:

> In passing on the validity of a state Medicaid plan under federal law, the court must determine whether the plan is procedurally and substantively in compliance with the requirements of the Federal Medicaid Act and its implementing regulations, and not limit its analysis to whether the nonadjudicatory agency findings are arbitrary and capricious.

*AMISUB (PSL), Inc.* v. *Colorado Dep't of Social Serves.* (10th Cir. 1989), 879 F.2d 789, *cert. denied*, (1990) 110 S.Ct. 3212.

9. Thus, issues such as whether the state Medicaid reimbursement rates meet the requirements of the federal statute and regulations is "an issue of law, subject to de novo review in [a court of competent jurisdiction]. The state agency's determination of procedural and substantive compliance with federal law is not entitled to the deference afforded a federal agency". *AMISUB*, 879 F.2d at 795-96.

10. Furthermore, the Court's review is limited to the administrative record as it existed at the time the agency took whatever action the Court is reviewing. See, *California Hosp. Assn.* v. *Schweiker* (D.C. Cal. 1982), 559 F.Supp. 110, 116, aff'd, (9th Cir. 1983, 705 F.2d 466, citing *Asarco, Inc.* v. *EPA* (19th Cir. 1980), 616 F.2d 1153, 1160. "[P]ost hoc rationalizations" offered by an agency in an attempt to justify its actions may not be considered by the court. See, *Burlington Truck Lines* v. *United States* (1962), 371 U.S. 156, 168-69; *Rodway* v. *United States Dept. of Agriculture* (D.C. Cir. 1975), 514 F.2d 809-816. Rather, the agency's action must be judged solely on record and on the evidence it possessed at the time it made its decision. See, *Securities & Exchange Comm.* v. *Chenery Corp.* (1947), 332 U.S. 194, 196.

11. In reviewing the state's Medicaid plan, the Court must first determine whether the plan was prepared procedurally and substantively in compliance with the federal Medicaid Act and its implementing regulations. *AMISUB*, 879 F.2d at 795. If the Court finds that the plan is in procedural and substantive compliance with federal law, the Court will limit its review to whether the agency's actions were arbitrary and capricious. *Id.*; *Mississippi Hospital Assn.* v. *Heckler,* (5th Cir. 1983), 701 F.2d 511, 516.

12. *AMISUB (PSL), Inc,* v. *Colorado Dep't of Social Serves.* (10th Cir. 1989), 879 F.2d 789, 795, holds that courts must determine de novo whether the state plan and resultant payment rates meet the requirements of federal law. Thus, a "state [Medicaid] agency's determination of [its own] procedural and substantive compliance with *federal* law is not entitled to the difference afforded a *federal* agency". *Id.* at 796 (emphasis added in original); see also, *Turner* v. *Perales* (1d cir. 1989), 869 F.2d 140, 141-42 (question whether state law and regulations are consistent with federal law is entitled to de novo review); *Colorado Health Care Assn.* v. *Colorado Dept. of Social Services* (10th Dir. 1988), 842 F.2d 1158, 1165; *Mississippi Hosp. Assn.* v. *Heckler* (5th Cir. 1983), 701 F.2d 511, 516; *Folden* v. *Washington Dept. of Social Services* (W.D. Wash. 1990), 744 F.Supp. 1507, 1525, appeal pending (9th Cir.), Nos. 353971, 90-35475; *Mary Washington Hospital* v. *Fisher*

(E.D. Va. 1985), 635 F.Supp. 891, 897. Where, as here, the central issue is whether the Indiana reimbursement regulations and the state plan violate federal law, state agencies should receive no deference from this Court.

13. Furthermore, deference to DPW is unwarranted because the administrative record upon which DPW made its rate-setting decision does not support those determinations. This Court's review is limited to the administrative record as it existed at the time the agency took the action being reviewed. See, *California Hosp. Assn.* v. *Schweiker* (D.C. Cal. 1982), 559 F.Supp. 110, 116, aff'd (9th Cir. 1983), 705 F.2d 466, citing *Asarco, Inc.* v. *EPA* (9th Cir. 1980), 616 F.2d 1153, 1160. this is the same requirement applied in cases under the Indiana Administrative Adjudication Act. See, e.g. *Indiana Dept. of Pub. Welfare* v. *Crescent Manor* (1981), Ind.App., 416 N.E.2d 470. *Glaser* v. *Dept. of Public Welfare* (1987), Ind.App., 512 N.E.2d 1128, 1133, holds that factual "findings entered by an administrative agency must be sufficient to inform the parties of the evidentiary bases upon which the ultimate findings rest, and to permit [the] court to engage in a meaningful review."

14. Deference to the rate-setting decisions in this case would be inappropriate because DPW did not make annual findings that payment rates complied with federal law. Indeed, there is no credible evidence that any official made a yearly finding. DPW officials did not undertake an annual objective and principled analysis of the readily available information. Such information plainly showed that nursing home rates were not reasonable or adequate to permit facilities to meet quality and safety standards.

15. Federal law requires payment rates that are:

> [R]easonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . .

42 U.S.C. § 1396a(a)(13)(A) (Supp. 1988).

16. Effective October 1, 1990, the Boren Amendment to the Medicaid Act (42 U.S.C. § 1396a(a)(13)(A) (1980), was amended, and established a higher substantive payment standard, providing that states must provide payment to nursing facilities:

> [T]hrough the use of rates determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, *take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident eligible for benefits under this subchapter) . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards* . . .

42 U.S.C. § 1396a(a)(13)(A) (Supp. 1991) (emphasis added). This higher payment standard is currently in effect, and governs Plaintiffs' federal claims as of October 1, 1990.

17. Indiana state law also establishes a substantive standard governing the adequacy of Medicaid payments to long term care facilities for services rendered to beneficiaries of the state Medicaid program. I.C. 12-1-7-17.6(B) (1990) provides that payment for nursing home care:

> [S]hall, under 42 U.S.C. §1396a(a)(13)(A), be determined in accordance with a prospective payment rate that is reasonable and adequate to meet the costs that are incurred by efficiently and economically operated facilities in order to provide care and services in conformity with State and Federal laws, rules, regulations,

> and quality and safety standards, with a growth or profit factor, as determined in accordance with generally accepted accounting principles . . .

The state law standard places more stringent requirements on the state than the Boren Amendment standard.

18. The Boren Amendment creates an independent procedural and substantive rights that are enforceable through Section 1983, Title 42 of the United States Code. The rights conferred by Indiana state law are enforceable directly through a private right of action, and through an action based on the provider contracts between the state and the nursing homes.

19. The Boren Amendment also creates an implied right of action under federal law, and may also be asserted through an action based upon the provider contracts between the state and nursing homes.

20. The Boren Amendment requires a state to pay reasonable and adequate rates. See, *Wilder* (1990), 110 S.Ct. at 2518-19. A rate is, by definition, unreasonable unless it is adequate to cover the costs that efficiently and economically operated nursing homes incur to provide care to Medicaid patients that meets federal and state quality standards. See, *Wilder*, 110 S.Ct. at 2519. Rates must cover not only the cost of services at the time the rate is set, but also must take into account projected economic trends and conditions in the period when the rate will be in effect. See, e.g. *Wilder*, 110 S.Ct. at 2522, n. 17; *The Hillhaven Corp.* v. *Wisconsin Dept. of Health & Social Services* (E.D. Wis. 1986), 634 F. Supp. 1313, 1319; Senate Committee on Finance, 96th Cong., 2d Sess., Spending Reductions: Recommendations of the Committee on Finance at 44-45 (Comm. Print 1980), *reprinted in* 126 Cong. Rec. S 8256-57 (June 25, 1980). Congress mandated "high quality care" and precluded the states from implementing "arbitrary reductions in payment that would adversely affect the quality of care". *Wilder*, 110 S.Ct. at 2520, quoting the Boren Amendment's legislative history.

21. The substantive requirement of the Boren Amendment to pay reasonable rates may be violated either of two ways. First, a state plan may violate the statute because the payment methodology is not designed to produce reasonable and adequate rates. See, e.g., 55 Fed. Reg. 7034 (Feb. 28, 1990) (notice of hearing regarding disapproval of proposed Louisiana state plan amendment); see also, Plaintiffs' Exhibit 48, attachments BT-5, 6, 7, 8 and 9, which are letters reflecting the Health Care Financing Administrations' ("HCFA") position on a Missouri proposed plan amendment. Second, if the rates are in fact unreasonable and inadequate, a Boren Amendment violation exists, regardless of whether the plan itself complies with the law. See, *Wilder*, 110 S. Ct. at 2519, discussing 42 C.F.R. § 430.35 (1989).

22. Satisfaction of the substantive requirement of the Boren Amendment generally is determined by analyzing the relationship between the Medicaid rates and the aggregate costs actually incurred on statewide basis to deliver services meeting quality of care standards. *Wilder*, 110 S.Ct. at 2520; *Colorado Health Care Assn.* v. *Colorado Dept. of Social Services* (10th Cir. 1988), 842 F.2d 1158, 1167; *AMISUB, 879 F.2d at 797*; *Thomas* v. *Johnston* (W.D. Tex. 1983), 557 F.Supp. 879, 914-15. There is no bright line which distinguishes a reasonable and adequate rate from one which is unreasonable. *Colorado Health Care Assn.*, 842 F.2d at 1168; see, 48 Fed. Reg. 56049 (Dec. 19, 1983). If, however, a substantial portion of nursing homes—generally more than 50%—do not receive rates covering their *actual* costs, both HCFA and the courts routinely find a violation of the Boren Amendment.

23. For example, HCFA has refused to approve state plans which fail to reimburse more than 50% of a state's providers for the actual costs of delivering Medicaid services. See, e.g. Health Care Financing Administration Notice of Hearing, 55 Fed. Reg. 1518, 1519 (Jan. 16, 1990) (notice of hearing, concerning disapproval of Colorado state plan's reimbursement methodology). In some cases, even state plans which failed to reimburse the Medicaid costs incurred by less than one-half of a state's facilities—

40%—have been denied approval by HCFA under the Boren Amendment. See, Health Care Financing Administration Notice of Hearing, 55 Fed. Reg. 7034 (Feb. 28, 1990) (notice of hearing concerning disapproval of Louisiana state plan's reimbursement methodology). Most recently, HCFA disapproved Missouri's state plan amendment where the state's data indicated a *substantial* number of the most efficiently operated facilities would not recover their full actual costs. See, Health Care Financing Administration Notice of Hearing, 55 Fed. Reg. 46873 (Nov. 7, 1990) (notice of hearing concerning disapproval of state plan amendment). This Court took judicial notice of HCFA's notices of plan disapproval cited above. Recently, the court in *Health Care Assn. of Michigan* v. *Babcock*, Medicare and Medicaid Guide (CCH) 39,182 at 23,106, noted HCFA's use of the informal 50% benchmark.

24. The court rulings are also clear. In *Nebraska Health Care Assn., Inc.* v. *Dunning*, Medicare and Medicaid Guide (CCH) ¶34,100 at 9935-36, the court found a violation for the Boren Amendment where 131 of 177 providers (74%) did not receive their costs of delivering Medicaid services. In *Thomas* v. *Johnston*, 557 F.Supp. at 914-15, the court held that the Boren Amendment was violated because the state failed to reimburse providers above the 40th percentile of Medicaid costs (i.e., 60% were not reimbursed their costs). Another court found a substantial likelihood of a Boren Amendment violation where a state's reimbursement methodology did not reimburse providers above the 60th percentile (i.e., 40% of providers were not being reimbursed their costs). *Oklahoma Hosp. Assn.* v. *Oklahoma Dept. of Human Services*, Medicare & Medicaid Guide (CCH), ¶33,057 at 10,249-50 (W.D. Okla. Aug. 24, 1983) (preliminary injunction denied on other grounds). But see, *Colorado Health Care Assn.* 842 F.2d 1158 (upholding fixed ceiling at 90th percentile); *Mississippi Hosp. Assn., Inc.*, v. *Heckler*, (5th Cir. 1983), 701 F.2d 511, 517-18 (80th percentile).

25. No court or HCFA has adopted a comparison of per diem rates to some arbitrary fraction of actual incurred costs.

Any downward adjustment of actual costs in the cost versus rate comparison is not legally supportable under the well-established Boren Amendment cases, and HCFA standards. For example, the court in *Folden* held that "the most accurate comparison of costs to rates should include an exact amount for the complete rates paid and an exact amount for *all* true costs". 744 F.2d at 1522 (emphasis added).

26. The removal of depreciation from the "actual cost" side of the comparison is rejected. The state plan itself recognizes depreciation as a facility cost. See, 470 IAC 5-4.1-12(a) (1990). Generally Accepted Accounting Principles ("GAAP") recognize depreciation as a cost and the state statute and state plan, both require facilities to follow GAAP in reporting cases. 470 IAC 5-4.1-3(a) (1990).

27. The case law is clear on another point. Rates may not be set based solely upon budgetary considerations. While a state may permissibly consider budgetary constraints in designing its Medicaid payment methodology, "the *conclusive* factor in rate determinations must not be the amount of money appropriated by a given state's legislature; rather the state Medicaid agency must make an objective, principled decision with regard to what rates are reasonable and adequate". *Thomas* v. *Johnston*, 557 F.Supp. at 914 (emphasis in original); see also, *AMISUB, 879 F.2d at 800; Illinois Hosp. Assn.* v. *Illinois Dept. of Pub. Aid* (N.D. Ill. 1983), 576 F.Supp. 360, 368; *Coalition of Michigan Nursing Homes* v. *Dempsey* (E.D. Mich. 1982), 537 F.Supp. 451, 463.

28. This Court concludes, as a matter of law, that payment rates violated the Boren Amendment for several reasons. First, DPW had no reasonable basis for capping reimbursement for staffing costs at the chosen levels. Clearly, for the past five years, facilities exceeded the staffing maximum. DPW ignored this information, or failed to investigate further, regarding the serious impact the staffing cap has had on facilities and their residents. This failure is particularly significant, given the fact that the Board of Health raised the minimum staffing requirement under the licensure standards in 1984. See, 410 IAC 16.2-3-5 (1984).

Over the years, DPW did not consider any factors relevant to determining whether rates computed using the staffing cap would be adequate to pay to providers services in compliance with federal and state laws. Rather, the state focused solely on budgetary considerations.

29. Similarly, DPW had no reasonable basis for limiting annual rate increases using the GNP/ipd. The GNP/ipd was chosen in 1983 for budgetary reasons, and has been maintained in place since then, solely as a cost containment device. The GNP/ipd has not kept pace with the cost increases incurred by efficiently and economically operated facilities. Again, DPW ignored the obvious negative impact of the GNP/ipd on facilities and their residents. Because DPW ignored the clear and widening gap between facility cost increases and the GNP/ipd, this Court concludes that DPW did not, and could not have, made proper findings that rates were adequate.

30. Plaintiffs have submitted substantial evidence in support of their claims that DPW failed to comply with federal law. This Court finds, as a matter of law, that the class has proved, by a preponderance of the evidence, that there are facilities in Indiana which are efficiently and economically operated that do not have their costs covered by their rates.

31. The Court concludes, as a matter of law, from all of the evidence, that the entire reimbursement system, and in particular the limit on annual rate increases, the test of reasonableness and the staffing cap, results in Indiana facilities being paid rates below the standards required by 42 U.S.C. § 1396a(a)(13)(A) and I.C. 12-1-7-17.6(B), at least since the rate year beginning April 1, 1987.

32. The Court also concludes, as a matter of law, that the class also has established that DPW did not make findings supported by a reasonable factual basis each year since April, 1983. Accordingly, Defendants continued implementation and operation of the payment system was arbitrary and capricious and contrary to law.

33. Plaintiffs and intervenors have properly demonstrated that aggregate rates, on a statewide basis, have not been reasonable and adequate under federal and state law. The proof lies, in large part, in (1) the comparison of actual incurred facility costs and the rates paid since 1987; (2) the substantial percentages of facilities whose rates did not meet their costs; (3) the obvious downward trend in the adequacy of payment; and (4) the substantial difficulty facilities have had in meeting prevailing quality of care requirements since mid-1987.

34. The party asserting the affirmative defense of laches has the burden of proof by a preponderance of the evidence. To support a defense of laches, Defendants herein must prove three things: (1) an inexcusable delay by Plaintiffs in asserting their rights; (2) an implied waiver by Plaintiffs arising from knowledge of existing conditions and an acquiescence in them; (3) circumstances causing Defendants prejudice. See, *Jordan*, 549 N.E.2d at 384; *Shearer* v. *Pla-boy, Inc.* (1989), Ind.App., 539 N.E.2d 247, 254; *Siddall* v. *City of Michigan City* (1985), Ind. App., 485 N.E.2d 912, 916; *Pickett* v. *Pickett* (1984), Ind.App., 470 N.E.2d 751, 754.

35. Laches is a defense to equitable claims. As the equitable claims in this case are moot, the defense of laches is moot.

36. Defendants neither have proved the second element of the laches defense—that plaintiff impliedly waived their rights by knowingly acquiescing in existing conditions. Defendants' own witnesses (Blinzinger and Magnant) testified that the nursing home industry began complaining about the adequacy of reimbursement in 1987. This hardly constitutes an implied waiver of the right to challenge Defendants' illegal payment system. Additionally, Defendants' argument that the nursing homes remained in the Medicaid program and continued to accept payment without filing suit proves nothing. This is just an argument based on the "mere passage of time" which cannot support a laches defense. See, *Shearer*, 538 N.E.2d at 254. There is no evidence in the record showing that the nursing home industry implicitly

consented to receiving illegal payment rates. Clearly, public policy would be disserved if the facilities could consent to inadequate reimbursement.

37. Defendants also failed to prove the third element of laches. They have not shown any prejudice *caused by* any delay on Plaintiffs' part. Any delay or lapse of time must "result in changed circumstances causing prejudice" to the defendant. *Summerlot*, 409 N.E.2d at 827. Remarkably, Defendants argue that Plaintiffs' inaction deprived DPW of the opportunity to change the reimbursement system, and to allocate its resources differently. This argument ignores the fact that the DPW has exclusive control over its programs, and may change them at will. DPW cannot excuse its own failure to ensure that payment rates are lawful and adequate by claiming that the nursing homes did not bring suit earlier. Furthermore, it is pure speculation that DPW would have changed its reimbursement system in response to an earlier lawsuit. Agnes Davidson, who worked for the budget agency and now DPW, surmised that DPW would have redesigned the rate-setting methodology if the GNP/ipd had been enjoined earlier. Ms. Davidson cannot speak for DPW. Besides, she has no factual basis for her bold assertions.

Indiana law is clear:

> Prejudice or injury to the adverse party is an essential element of laches, and the equity is slow to apply the doctrine of laches *where there is no change in the situation of the parties to the prejudice of the defendant during the delay.*

12 I.L.E., Equity § 55, cited in *City of Indianapolis* v. *Sherman* (1980), Ind.App., 409 N.E.2d 1202, 1207; *Ely* v. *City of Montpelier* (1969), 146 Ind.App. 175, 253 N.E.2d 286, 294.

38. Defendants have shown no substantial injury because of any claimed inaction by Plaintiffs. First, if DPW has suffered any prejudice, it was due to its own failure to evaluate properly the adequacy of its own payment system at least annually. Second,

after receiving complaints beginning in 1987 regarding the inadequacy of payment rates and the GNP/ipd, DPW did not change its system. Third, DPW's assertion of prejudice is based on its unsupported speculation that it "could have" budgeted for any money this Court might order be paid in damages in insufficient to establish prejudice. See, *Sherman*, 409 N.E.2d at 1207, citing *State ex rel Crooke* v. *Lugar* (1976), 171 Ind.app. 60, 354 N.E.2d 755. The law is clear that a governmental entity cannot show prejudice simply because it failed to appropriate funds necessary to meet its *legal obligations*. See, *Siddall* v. *City of Michigan City* (1986), Ind.App., 485 N.E.2d 912, 916. DPW alone bears responsibility for any speculated disruption to the state treasury that might result from its unlawful actions. If anything, DPW and the state treasury have benefitted to date by any alleged delay by Plaintiffs. They have had the benefit of using the moneys that should have been aid to the facilities dating back several years. Cf. *Ely*, 253 N.E.2d at 294.

39. Pursuant to 42 U.S.C. 1988, the intervening Plaintiffs are entitled to an award against the Defendants for attorney fees which they have incurred.

40. Pursuant to 42 U.S.C. 1988, the class is entitled to an award of attorney fees against the Defendants.

41. Pursuant to Trial Rule 23(D) of the Indiana Rules of Procedure, class counsel is entitled to an award of attorney fees from the fund created by the judgment herein.

42. With respect to attorney fees eventually awarded to class counsel, fees ordered to be paid by the Defendants pursuant to 42 U.S.C. 1988 shall be a credit against any fees by the Court from the fund created by the judgment entered herein.

DATED this 19 day of September, 1991.

JUDGE, HANCOCK CIRCUIT COURT

## APPENDIX D

| | | |
|---|---|---|
| **State of Indiana**<br>**County of Hancock** | **SS:** | **In the Hancock Circuit Court**<br>**Cause Number:**<br>**3OC01-9002-CP-125** |

TIOGA PINES LIVING CENTER, INC., COMMUNICARE OF INDIANA, INC. D/B/A AMERICAN VILLAGE RETIREMENT COMMUNITY, BLOOMINGTON CONVALESCENT CENTER, INC., MEADOW HEIGHTS NURSING CENTER, INC., D/B/A LINCOLN HILLS OF NEW ALBANY,

VS. *Plaintiffs,*

INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, AND SUZANNE MAGNANT, in her capacity as ADMINISTRATOR OF THE INDIANA DEPARTMENT OF PUBLIC WELFARE,

*Defendants.*

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**PARTIAL FINAL JUDGMENT ENTRY**

IT IS HEREBY ADJUDGED AND DECREED that the Medicaid reimbursement regulations which are the subject of this lawsuit violate the provisions of 42 U.S.C. § 1396a(a)(13)(A) and of Ind. Code § 12-1-7-17.6(b). In addition as was adjudged by this Court on February 7, 1991 the utilization of the so called tests of reasonableness were invalid because they were never duly promulgated. IT IS FURTHER ADJUDGED AND DECREED that the illegalities of the Medicaid reimbursement rate-setting regulations, which are the subject of this lawsuit have

caused the members of the class to be under-reimbursed their reasonable costs incurred in providing adequate care in conformance with applicable State and Federal regulations to Medicaid recipients living in their facilities. IT IS FURTHER ADJUDGED AND DECREED that the class should be repaid for all such under-reimbursement which occurred during the period beginning January 24, 1988 and ending March 31, 1991. IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the amount of under-reimbursement during that period is defined to be the difference in Medicaid reimbursement calculated without application of either the annual rate limiter (the GNP/ipd) or the "tests of reasonableness" less the amount of Medicaid reimbursement actually paid then multiplied by the number of Medicaid patient days. The calculation of under-reimbursement for the period June 1, 1990 through March 31, 1991 has already been made by this Court on the basis of financial statements filed by the defendants and stipulated by the class with this Court on June 26, 1990. The aggregate amount of under-reimbursement from June 1, 1990 through March 31, 1991 is computed to be $40,300,317. The amount of under-reimbursement which has accrued for the period of time January 24, 1988 through May 31, 1990, will be determined, as a separate issue, at a later date and after trial.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the class is entitled to recover from the defendants, attorney fees pursuant to 42 U.S.C. § 1988 in the amount of $533,000, and expenses in the amount of $32,000.

IT IS FURTHER ORDERED ADJUDGED AND DECREED that class counsel is entitled to attorney fees from the fund created by this judgment pursuant to the provisions of Trial Rule 23(D) of the Indiana Rules of Procedure in the amount of 25% of the fund created by this judgment or $10,075,079.25, together with expenses in the amount of $53,279.80. In addition, class counsel for the benefit of class members who have already

advanced expenses for expert witness fees, be paid the sum of $330,960.41 which amount has been paid to expert witnesses, Jazwiecki, Johnson and Deane.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the intervenors are entitled to recover from the defendants attorney fees pursuant to 42 U.S.C. § 1988 in the amount of $548,361 and expenses in the amount of $119,546.17.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that within 10 days of this order, the parties are to exchange proposed forms to be used for the presentation of claims by individual class members against the fund created by this judgment. The individual claims are to be made to C. Thomas Billings, the Master appointed previously by this Court. The claim form shall include copies of the forms submitted by the class members to the State to obtain the reimbursement that was paid during the period for which damages as a result of under-reimbursement are allowable herein. The forms shall also disclose the amount of reimbursement actually paid and shall calculate the difference between what was actually paid and what would have been paid on the basis of the budgets submitted if the annual limiter and tests of reasonableness were not applied to those budgets. The Master who was appointed pursuant to Trial Rule 53, shall accept claim forms and determine the amount of reimbursement to be paid to each class member.

The procedure for filing claims is as follows:

1. Within thirty (30) days of this Court's approval of forms for the presentation of claims by individual class members the forms shall be distributed to each member of the class by class counsel.

2. Together with the forms, class counsel shall notify the members of the class that forms must be returned to the Master within sixty (60) days in order to qualify for participation in the

distribution of damages for under-reimbursement awarded herein. The notice shall state that any claim received after sixty (60) days will be disallowed as untimely filed.

3. Immediately upon the receipt of claims by the Master, the Master shall forward copies of the claims to counsel for the class and counsel for the defendants.

4. Immediately upon receipt of any claim, the Defendant may challenge the claim. The only challenges that may be made by the Defendant are challenges that budgeted items are either inefficient or not economic. To make a challenge the defendant must state the budget item which is challenged, the dollar amount of that budget item they contend is due to inefficient or uneconomic operation and shall also specify the substance of the claim and the specific facts upon which they will rely to prove their claim that the challenged expense was generated by inefficient or uneconomic operation. The defendant may avail itself of any discovery process allowed by Indiana Rules of Trial Procedure in order to obtain information with which to substantiate its challenges. All challenges shall be completed and filed by the defendant within one hundred twenty (120) days of the defendant's receipt of the claim of each class member. Each class member whose claim is challenged by the State shall have thirty (30) days to respond to the challenge.

5. The Master shall pay any unchallenged claim within thirty (30) days of receipt.

6. The Master shall determine which challenges shall be allowed and to the extent a challenge is allowed, the Master shall file a report within thirty (30) days of his receipt of the claimant's response to the State's challenge indicating his acceptance of the challenge and the extent to which the claim will be reduced as a result of the challenge. The reduced claim shall be immediately paid to the claimant.

7. With respect to any claim which is challenged and the challenged amount not accepted by the Master, such claims shall

be returned to the Court for resolution after an evidentiary hearing specific to the amounts claimed and the challenges thereto.

8. With respect to any challenged claim with respect to which the challenge is accepted by the Master and the claim thereby reduced, the holder of such a reduced claim shall, within fifteen (15) days of the Master's report, appeal to the Court for determination in the event that the claimant disagrees with the Master's determination. As with respect to challenged claims not accepted by the Master, such claims shall be resolved by the Court after an evidentiary hearing specific to the amounts of challenge allowed by the Master and disputed by the claimant.

No reason shall exist which would prohibit this judgment from becoming a partial final judgment as to the issues addressed herein. The Court adjudges and decrees that there is no just reason for delay of the entry of this judgment and it is hereby ordered that this partial judgment shall be entered immediately as a final judgment and that the parties hereto immediately commence appeals on any issue resolved by this judgment pursuant to the provisions of the Indiana Rules of Procedure and specifically Trial Rule 54(B).

ALL OF WHICH IS ORDERED, ADJUDGED AND DECREED this 25 day of March, 1992.

_____

JUDGE, HANCOCK CIRCUIT COURT

## APPENDIX E

Regency Place of Castleton
5226 East 82nd Street
Indianapolis, IN 46250

Regency Place of Dyer
2300 Great Lakes Drive
Dyer, IN 46311

Regency Place of Fort Wayne
6006 Brandy Chase Cove
Fort Wayne, IN 46815

Regency Place of Greenfield
200 Green Meadows Place
Greenfield, IN 46140

Regency Place of Greenwood
1400 W. Main Street
Greenwood, IN 46142

Regency Place of Lafayette
300 Windy Hill Drive
Lafayette, IN 47905

Regency Place of South Bend
52654 N. Ironwood Road
South Bend, IN 46635

Brighton Hall Nursing Center
1201 Daly Drive
New Haven, IN 46774

Countryside Nursing Center
1001 Springwood Road
Terre Haute, IN 47802

Covington Manor Nursing Center
5700 Wilkie Drive
Fort Wayne, IN 46804

Decatur Nursing & Rehabilitation Center
4851 Tincher Road
Indianapolis, IN 46241

Norwood Nursing Center
3720 North Norwood Road
Huntington, IN 46750

Stone Manor Convalescent Center
8201 West Washington Street
P.O. Box 31196
Indianapolis, IN 46231

University Park Nursing Center
1400 Medical Park Drive
Fort Wayne, IN 46825

Eastgate Manor Nursing Home
2119 East National Hwy.
Washington, IN 47501

Meadow View Health Care Center
Homer & Anson Streets
Salem, IN 47167

Medco Center of Chandler
Gardner Road, Box 39
Chandler, IN 47610

Medco Center of Clarksville
517 North Hallmark Blvd.
Clarksville, IN 47130

Medco Center of Danville
255 Meadow Drive
Danville, IN 46122

Medco Center of Elkhart
2600 Morehouse Avenue
Elkhart, IN 46517

Medco Center of Evansville North
650 Fairway Drive
Evansville, IN 47710

Medco Center of Evansville West
25 South Boehne Camp Road
Evansville, IN 47712

Medco Center of Mt. Vernon
1415 Country Club Road
Mt. Vernon, IN 47620

Medco Center of Newburgh
4255 Medwell Drive
Newburgh, IN 47630

Medco Center of South Bend
1950 Ridgedale Road
South Bend, IN 46614

Medco Plaza of Fort Wayne
3636 Newport Avenue
Fort Wayne, IN 46805

Parkview Nursing Center
2200 Whiteriver Blvd.
Muncie, IN 47303

Professional Care Nursing Center
2000 North Road
Dale, IN 47523

Todd-Dickey Medical Center
A & 2nd Streets
Leavenworth, IN 47137

Medco Center of Fort Wayne
3811 Parnell Avenue
Fort Wayne, IN 46805

Medco Center of French Lick
Highway 145 and East College
French Lick, IN 47432

Gertha's Nursing Center
617 Oakley Street
Evansville, IN 47710

Columbia Nursing Plaza
621 West Columbia
Evansville, IN 47710

Crestview Convalescent Center
3801 Old Bruceville Road
Vincennes, IN 47591

Indian Creek Convalescent Ctr.
240 Beech Mont Drive
Corydon, IN 47112

Westfield Village
776 North Union Street
Westfield, IN 46074

Windsor Estates of Kokomo
429 West Lincoln Road
Kokomo, IN 46901

Wedgewood Manor Convalescent Ctr.
101 Potters Lane
Clarksville, IN 47130

Westview Manor Health Care Ctr.
1510 Clinic Drive
Bedford, IN 47421

Columbus Convalescent Ctr.
2100 Midway
Columbus, IN 47201

Hooverwood
7001 Hoover Road
Indianapolis, IN 46260

Little Company of Mary Health Facility
R.R. 1, Box 22A
San Pierre, IN 46374

Rolling Hills Convalescent Center
1821 Lindberg Road
Anderson, IN 46012

Angola Nursing Home
600 N. Williams Street
Angola, IN 46703

Bedford Nursing Home
514 E. 16th Street
Bedford, IN 41421

Westview Manor Health Care Center
1510 Clinic Drive
Bedford, IN 47421

Fontanbleu Nursing Center
3305 South Highway 37
Bloomington, IN 47402

Westhaven Nursing Home
1001 South Clark Ave.
Bluffton, IN 46714

Wedgewood Manor Conv. Center
101 Potters Lane
Clarisville, IN 47130

Clinton Nursing Home
700 South Main St.
Clinton, IN 47842

Columbia City Nursing Home
522 N. Line St.
Columbia City, IN 46725

Cottonwood Manor Nursing Home
5400 E. 25th Street
Columbus, IN 47201

Connersville Nursing Home
2600 N. Grand Avenue
Connersville, IN 47331

Corydon Nursing Home
315 New Middletown Road
Corydon, IN 47112

Indian Creek Conv. Center
240 Beech Mont Drive
Corydon, IN 47112

Carmen Nursing Home
817 Whitlock Avenue
Crawfordsville, IN 47933

Primrose Manor
337 W. Lincoln
Danville, IN 46122

Birchwood Manor
1433 S. Washington Street
Delphi, IN 46923

Fountainview Place
1001 West Hivey Avenue
Elkhart, IN 46517

Columbia Nursing Center
621 West Columbia
Evansville, IN 47710

Gertha's Nursing Center
617 Oakley Street
Evansville, IN 47710

Woodbridge Nursing Care Center
(REIT-OWNER)
816 First Avenue
Evansville, IN 47710

Fort Wayne Nursing Home
2402 N. Beacon Street
Fort Wayne, IN 46800

Three Rivers Conv. Center
2940 North Clinton Street
Fort Wayne, IN 46805

Frankford Nursing Home
1234 Rossville Avenue
Frankfort, IN 46041

Franklin Nursing Home
1130 North Main Street
Franklin, IN 46131

Fountainview Place of Goshen
2400 College Avenue
Goshen, IN 46526

Greencastle Nursing Home
815 E. Tacoma Drive
Greencastle, IN 46135

Brandywine Manor
745 North Swope Street
Greenfield, IN 46140

Sugar Creek Conv. Center
5430 West U.S. 40
Greenfield, IN 46140

North Lincoln Village
1420 N. Lincoln St.
Greensburg, IN 47240

Hammond Nursing Home
1402 E. 173rd Street
Hammond, IN 46324

Highland Nursing Home
9630 5th Street
Highland, IN 46322

Huntington Nursing Home
1425 Grant Street
Huntington, IN 46750

Broad Ripple Nursing Home
6127 N. College Avenue
Indianapolis, IN 46220

Brookview Manor
7145 East 21st Street
Indianapolis, IN 46219

Churchman Manor
2860 Churchman Avenue
Indianapolis, IN 46203

Continental Conv. Center
344 South Ritter Avenue
Indianapolis, IN 46219

Del Mar Nursing Home
709 S. Lynhurst Drive
Indianapolis, IN 46241

Emerson Nursing Home
3420 N. Emerson Avenue
Indianapolis, IN 46218

Fountainview Place
5353 E. Raymond Street
Indianapolis, IN 46203

Greenbriar Manor
8181 Harcourt Road
Indianapolis, IN 46260

Hallmark Manor Nursing Home
6851 E. Tenth Street
Indianapolis, Indiana 46219

Meridian Nursing Home
2102 S. Meridian Street
Indianapolis, IN 46225

North Willow Center
2002 West 86th Street
Indianapolis, IN 46260

Southeastern Nursing Home
4743 Southeastern Avenue
Indianapolis, IN 46203

Warren Park Nursing Home
6855 E. 10th Street
Indianapolis, IN 46219

Westview Nursing Home
5435 W. 38th Street
Indianapolis, IN 46254

Jeffersonville Nursing Home
1720 E. 8th St.
Jeffersonville, IN 47130

Kendallville Nursing Home
1433 S. Main Street
Kendallville, IN 46755

Kentland Nursing Home
720 E. Washington St.
Kentland, IN 57951

Countryside Place
Route 3, Box 6, 300 Culver Road
Knox, IN 46534

Sycamore Village Health Care
2905 W. Sycamore Road
Kokomo, IN 46901

Windsor Estates of Kokomo
429 West Lincoln Road
Kokomo, IN 46901

Countryside Place
1700 "I" Street
La Porte, IN 46350

Fountainview Terrace
1900 Andrew Avenue
La Porte, IN 46350

South Street Healthcare Center
1123 E. South Street
Lafayette, IN 47901

LaGrange Nursing Home
Townline Road and North Street
LaGrange, IN 46761

Essex Manor
301 W. Essex Street
Lebanon, IN 46052

Linton Nursing Home
1501 E. "A" Street
Linton, IN 47441

Madison Nursing Home
1945 Cragmont Street
Madison, IN 47250

Southlake Care Center
8800 Virginia Place
Merrillville, IN 46410

Countryside Place
811 E. 12th Street
Mishawaka, IN 46544

Fountainview Place of Mishawaka
609 W. Tanglewood Lane
Mishawaka, IN 46545

Fountainview Place
2701 Lyn-Mar Drive
Muncie, IN 74302

New Albany Nursing Home
1919 Bono Road
New Albany, IN 47150

Holly Hill Nursing Home
901 N. 16th Street
New Castle, IN 47362

Newburgh Health Care & Resident Center
10466 Pollack Avenue
Newburgh, IN 47630

Noblesville Nursing Home
1791 Greenfield Pike
Noblesville, IN 46060

North Vernon Nursing Home
801 N. Elm Street
North Vernon, IN 47265

Paoli Nursing Home
111 W. Hospital View Road
Paoli, IN 47454

Peru Nursing Home
390 West Blvd.
Peru, IN 46970

Petersburg Healthcare Center
(REIT-OWNER)
Pike Avenue, Box 100
Petersburg, IN 47567

Mayflower Nursing Home
309 Kingston Drive
Plymouth, IN 46563

Fountainview Place of Portage
3175 Lancer Street
Portage, IN 46368

Golden Rule Nursing Center
2001 U.S. #27, South
Richmond, IN 47374

Oak Ridge Conv. Center
(REIT-OWNER)
1042 Oak Drive
Richmond, IN 47374

Rochester Nursing Home
240 E. 18th Street
Rochester, IN 46975

Castle Shannon Nursing Home
Rural Route #3, Box 251
Rockville, IN 47872

Scottsburg Nursing Home
1100 N. Gardner Street
Scottsburg, IN 47170

Northwood Nursing
328 N. Notre Dame Avenue
South Bend, IN 46617

Village Nursing Home
975 N. Section Street
Sullivan, IN 47882

Lincoln Hills Nursing Home
402 19th Street
Tell City, IN 47586

Maplewood Manor
500 Maple Avenue
Terre Haute, IN 47804

Tipton Nursing Home
701 E Jefferson Street
Tipton, IN 46082

Canterbury Place Nursing Center
251 East Drive
Valparaiso, IN 46383

Crestview Conv. Center
3801 Old Bruceville Road
Vincennes, IN 47591

Lakeland Manor
2402 E Center Street
Warsaw, IN 46560

Winamac Nursing Home
515 East 13th Street
Winamac, IN 46996

Batesville Health Care Center
"Dreyerhaus"
958 East Highway 46
Batesville, IN 47006

Chesterton Health Care Center
1620 South Old State Rd 49
Chesterton, IN 46304

Clifty Falls Conv. Center
950 Cross Avenue
Madison, IN 47250

Covington Manor Health Care Ctr
1600 East Liberty Street
Covington, IN 47932

Dillsboro Manor Health Care Ctr
P.O. Box 37 Lenover Street
Dillsboro, IN 47018

Forest Del Conv. Center
1020 West Vine Street
Princeton, IN 47670

Garfield Park Health Facility
3895 South Keystone Avenue
Indianapolis, IN 46227

Heritage House Conv. Center
1601 Hospital Drive
Greencastle, IN 46135

Heritage House Conv. Center
2055 Heritage Drive
Martinsville, IN 46151

Huntingburg Conv. Center
1712 Leland Drive
Huntingburg, IN 47542

Autumn Care of Brownsburg
1010 Hornaday Road
Brownsburg, IN 46112

Autumn Care of Castleton
7630 E 86th Street
Indianapolis, IN 46256

Autumn Care of Ladoga
1001 E Main Street
Ladoga, IN 47954

Regina Continuing Care Center
3900 Washington Avenue
Evansville, IN 47715

Summit Conv. Center
P.O. Box 398
Summitville, IN 46070

Bremen Health Care Center
316 Woodies Lane
Bremen, IN 46506

Chalet Village
1065 Parkway Street
Berne, IN 46711

Ben Hur Home, Inc.
1375 S Grant Avenue
Crawfordsville, IN 47933

Houston Health Care, Inc.
34 S Main Street
Cloverdale, IN 46120

Houston Health Care, Inc.
1371 S Grant Avenue
Crawfordsville, IN 47933

Houston Village, Inc.
5055 W 52nd Street
Indianapolis, IN 46222

Clark's Creek Healthcare Ctr
3700 Clark's Creek Road
Plainfield, IN 46168

and a class consisting of all Medicaid-certified nursing homes in Indiana, not including intermediate care facilities for the mentally retarded. Community Care Centers, Inc., and the Indiana Health Care Association, a trade association representing over 450 Indiana nursing homes, were parties to an appeal consolidated with the appeal petitioners are asking this Court to review.

## APPENDIX F

American Health Care, Inc.
American Pharmaceutical Corporation, Inc.
Barclay Holdings, Inc.
Batesville Health Care Center, Inc.
Beverly Enterprises - Indiana, Inc.
Beverly California Corporation
Beverly Enterprises, Inc.
Bloomington Convalescent Center, Inc.
Care One, Inc.
Chesterton Health Care Center, Inc.
Continental Care Center, Inc.
Conves-Care, Inc.
Countryside Care Center Corporation
Covington Manor, Inc.
CROWNX, Inc.
CROWNX Properties, Inc.
Daughters of Charity National Health System, Inc.
Delphi Healthcare Center, Inc.
DHE, Inc.
Extendicare Health Services, Inc.
Forest City Building Limited
Georgetown Manor, Inc.
Harborside Health I Corp.
Heritage House Convalescent Center of Putnam County, Inc.
Heritage House Convalescent Center of Martinsville, Inc.
Hillhaven Corporation, Inc.
Holy Cross Care Services, Inc.
Hooverwood Indianapolis Jewish Home, Inc.
Jewish Federation of Greater Indianapolis, Inc.
Krupp Yield Plus Limited Partnership
Local Council of Women, Inc.
Madison Healthcare, Inc.
Meadow Heights Nursing Center, Inc.
MidWest Care Center, Inc.
Nationwide Management, Inc.

NCS, Inc.
Northern Health Facilities, Inc.
Pilgrim Manor, Inc.
Princeton Healthcare, Inc.
RES-CARE, Inc.
Riverside Retirement Limited Partnership
St. Mary's Medical Center, Inc.
Shive Nursing Centers, Inc.
Southeastern Healthcare Services, Inc.
Southwestern Healthcare Services, Inc.
Summt Convalescent Center, Inc.
Tioga Pines Living Centers, Inc.
Unicare Health Facilities, Inc.
Unicare Homes, Inc.
United Health, Inc.
United Holdings, Inc.

## APPENDIX G

U.S. Const. amend. I:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people to assemble, and to petition the Government for a redress of grievances.

U.S. Const. amend XIV, section 2:

> Sect. I. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. Const. art. VI, cl. 2:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

42 U.S.C. § 1983:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party

injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

42 U.S.C. § 1396a(a)(13)(A):

A State plan for medical assistance must—

provide—(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care, and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title)), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(V)(1)(G) of this title) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be

incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports;

## 42 C.F.R. §§ 447.250-447.256

**§447.250 Basis and purpose.**

(a) This subpart implements section 1902(a)(13)(A) of the Act, which requires that the State plan provide for payment for hospital and long-term care facility services through the use of rates that the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards.

(b) Section 447.253(a)(2) implements section 1902(a)(30) of the Act, which requires that payments be consistent with efficiency, economy, and quality of care;

(c) Sections 447.253 (c) and (d) implement sections 1902(a)(13)(B) and 1902(a)(13)(C) of the Act, which require a State Medicaid agency to make certain assurances to the Secretary regarding increases in payments resulting solely from changes in ownerships of hospitals, NFs, and ICFs/MR.

(d) Section 447.271 implements section 1903(i)(3) of the Act, which requires that payments for inpatient hospital services not exceed the hospital's customary charges.

(e) Section 447.280 implements section 1913(b) of the Act, which concerns reimbursement for long-term care services furnished by swing-bed hospitals.

[48 FR 56057, Dec. 19, 1983, as amended at 57 FR 43921, Sept. 23, 1992]

EFFECTIVE DATE NOTE: At 57 FR 43921, Sept. 23, 1992, in § 447.250, paragraphs (c) and (d) were redesignated as (d) and (e) and a new (c) added, effective October 23, 1992.

## PAYMENT RATES

**§ 447.251 Definitions.**

For the purposes of this subpart—

*Long-term care facility services* means intermediate care facility services for the mentally retarded (ICF/MR) and nursing facility (NF) services.

*Provider* means an institution that furnishes inpatient hospital services or an institution that furnishes long-term care facility services.

[46 FR 47971, Sept. 30, 1981, as amended at 54 FR 5359, Feb. 2, 1989; 56 FR 48867, Sept. 26, 1991]

**§ 447.262 State plan requirements.**

(a) The plan must provide that the requirements of this subpart are met.

(b) The plan must specify comprehensively the methods and standards used by the agency to set payment rates in a manner consistent with § 430.10 of this chapter.

(c) If the agency chooses to apply the cost limits established under Medicare (see § 413.30 of this chapter) on an individual provider basis, the plan must specify this requirement.

(Approved by the Office of Management and Budget under control number 0938-0193)

[48 FR 56058, Dec. 19, 1983, as amended at 51 FR 34833, Sept. 30, 1986]

**§ 447.253 Other requirements.**

(A) *State assurances.* In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through

(i) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) *Findings.* Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) *Payment rates.* (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to inpatient hospital services—

(A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;

(B) If a State elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services) under conditions similar to those described in section 1861(v)(1)(G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level ~~of care~~ services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act; and

(C) The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

(iii) With respect to nursing facility services—

(A) Except for preadmission screening for individuals with mental illness and mental retardation under § 483.20(f) of this Chapter, the methods and standards used to determine payment rates take into account the costs of complying with the requirements of part 483 subpart B of this chapter;

(B) The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in § 483.30(c) of this Chapter to provide licensed nurses on a 24-hour basis;

(C) The State establishes procedures under which the data and methodology used in establishing payment rates are made available to the public.

(2) *Upper payment limits.* The agency's proposed payment rate will not exceed the upper payment limits as specified in § 447.272.

(c) *Changes in ownership of hospitals.* In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards must provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than the payments would increase under Medicare under §§413.130, 413.134, 413.153, and 413.157 of this chapter, insofar as these sections affect payments for depreciation, interest on capital indebtedness, return on equity capital (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

(d) *Changes in ownership of NFs and ICFs/MR.* In determining payment when there has been a sale or transfer of assets of an NF or ICF/MR, the State's methods and standards must provide the following depending upon the date of the transfer.

(1) For transfers on or after July 18, 1984 but before October 1, 1985, the State's methods and standards must

provide that payment rates can reasonably be expected not to increase in the aggregate, solely as the result of a change in ownership, more than payments would increase under Medicare under §§413.130, 413.134, 413.153 and 413.157 of this chapter, insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity capital (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

(2) For transfers on or after October 1, 1985, the State's methods and standards must provide that the valuation of capital assets for purposes of determining payment rates for NFs and ICFs/MR is not to increase (as measured from the date of acquisition by the seller to the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of—

(i) One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or

(ii) One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.

(e) *Provider appeals.* The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence

and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

(f) *Uniform cost reporting.* The Medicaid agency must provide for the filing of uniform cost reports by each participating provider.

(g) *Audit requirements.* The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers.

(h) *Public notice.* The Medicaid agency must provide that it has complied with the public notice requirements in §447.205 of this part when it is proposing significant changes to its methods or standards for setting payment rates for inpatient hospital or LTC facility services.

(i) *Rates paid.* The Medicaid agency must pay for inpatient hospital and long term care services using rates determined in accordance with methods and standards specified in an approved State plan.

[48 FR 56057, Dec. 19, 1983, as amended at 52 FR 28147, July 28, 1987; 54 FR 5359, Feb. 2, 1989: 57 FR 43921, Sept. 23, 1992]

EFFECTIVE DATE NOTE: At 57 FR 43921, Sept. 23, 1992, in §447.253 paragraph (a) was amended by changing the phrase "paragraphs (b) through (g)" to read "paragraphs (b) through (i)", paragraphs (c) through (g) were redesignated as (e) through (i), respectively, and new paragraphs (c) and (d) were added, effective October 23, 1992.

**§ 447.255 Related information.**

The Medicaid agency must submit, with the assurances described in § 447.253(a), the following information:

(a) The amount of the estimated average proposed payment rate for each type of provider (hospital, ICF/MR, or nursing facility), and the amount by which that estimated average rate

increased or decreased relative to the average payment rate in effect for each type of provider for the immediately preceding rate period:

(b) An estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on—

(1) The availability of services on a Statewide and geographic area basis;

(2) The type of care furnished;

(3) The extent of provider participation; and

(4) The degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

[48 FR 56058, Dec. 19, 1983, as amended at 54 FR 5359, Feb. 2, 1989; 56 FR 48867, Sept. 26, 1991; 57 FR 43924, Sept. 23, 1992]

**§ 447.256 Procedures for HCFA action on assurances and State plan amendments.**

(a) *Criteria for approval.* (1) HCFA approval action on State plans and State plan amendments, is taken in accordance with subpart B of part 430 of this chapter and sections 1116, 1902(b) and 1915(f) of the Act.

(2) In the case of State plan and plan amendment changes in payment methods and standards, HCFA bases its approval on the acceptability of the Medicaid agency's assurances that the requirements of § 447.253 have been met, and the State's compliance with the other requirements of this subpart.

(b) *Time limit.* HCFA will send a notice to the agency of its determination as to whether the assurances regarding a State plan amendment are acceptable within 90 days of the date HCFA receives the assurances described in § 447.253, and the related information described in § 447.255 of this subpart. If HCFA does not send a notice to the agency of its determination within this

time limit the provisions in paragraph (a) of this section are met, the assurances and/or the State plan amendment will be deemed accepted and approved.

(c) *Effective date.* A State plan amendment that is approved will become effective not earlier than the first day of the calendar quarter in which an approvable amendment is submitted in accordance with § 430.20 of this chapter and 447.253.

[48 FR 56058, Dec. 19, 1983, as amended at 52 FR 28147, July 28, 1987]

## APPENDIX H

| | | |
|---|---|---|
| **State of Indiana**<br>**County of Hancock** | **SS:** | **In the Circuit Court of**<br>**Hancock County**<br>**Cause No. 30C01-9002-CP-125** |

TIOGA PINES LIVING CENTER, INC., COMMUNICARE OF INDIANA, INC., d/b/a AMERICAN VILLAGE RETIREMENT COMMUNITY, BLOOMINGTON CONVALESCENT CENTER, INC., MEADOW HEIGHTS NURSING CENTER, INC., d/b/a LINCOLN HILLS OF NEW ALBANY,

*Plaintiffs,*

vs.

INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, SUZANNE MAGNANT, in her capacity as ADMINISTRATOR of the INDIANA STATE DEPARTMENT OF PUBLIC WELFARE,

*Defendants.*

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**AMENDED**
**COMPLAINT FOR PRELIMINARY AND PERMANENT INJUNCTION, DECLARATORY JUDGMENT AND DAMAGES**

Come now Tioga Pines Living Center, Inc.; Communicare of Indiana, Inc., d/b/a American Village Retirement Community; Bloomington Convalescent Center, Inc.; and Meadow Heights Nursing Center, Inc., d/b/a Lincoln Hills of New Albany and for their claim for relief against defendants say:

I.

1. Tioga Pines Living Center, Inc. is an Indiana corporation with its principal place of business located at 410 Tioga Road, Monticello, Indiana 47960.

2. Communicare of Indiana, Inc., d/b/a American Village Retirement Community, is an Indiana corporation with its principal place of business located at 2026 E. 54th Street, Indianapolis, Indiana 46220.

3. Bloomington Convalescent Center, Inc. is an Indiana not-for-profit corporation with its principal place of business located at 714 South Rogers, Bloomington, Indiana 47401.

4. Meadow Heights Nursing Center, Inc., d/b/a Lincoln Hills of New Albany is an Indiana corporation with its principal place of business located at 326 Country Club Road, New Albany, Indiana 47150.

5. Plaintiffs are licensed under the provisions of IC 16-10-4 and are certified for reimbursement by the Indiana Medicaid Program in accordance with applicable state and federal statutes and regulations.

6. The defendant, Indiana State Department of Public Welfare ("DPW") is the state agency responsible for administering the Medicaid reimbursement program in Indiana.

7. The defendant, Indiana State Board of Public Welfare ("DPW Board") is created by IC 12-1-15.2 and is responsible, pursuant to IC 12-1-2-2 for the adoption of rules governing the DPW. The DPW Board consists of seven members, four of whom constitute a quorum for the transaction of business. Defendant Suzanne Magnant is the Administrator of DPW.

8. The defendants have contracted with Myers and Stauffer, certified public accountants, based in Topeka, Kansas, to act as the defendants' rate setter for the Indiana Medicaid Program.

9. This controversy arises in part from a decision by DPW to apply a new rule to the Medicaid reimbursement program beginning August 8, 1988. The rule is set forth in LSA Doc. #88-33, a copy of which is attached hereto and marked Exhibit A. This new rule would constitute a major revision of 470 IAC 5-4.1 et seq. which governs Medicaid rates for long-term care facilities. It also arises out of the defendants using unpromulgated rules to set facility rates and in addition it arises out of the invalidity of one section of the rule which is contrary to the federal and state statutory requirements of reimbursement.

10. This action arises, in part, under the Constitution of the United States and the provisions of 42 U.S.C. §1983, in part under IC 34-4-10, the Indiana Declaratory Judgment Act, and under IC 4-21.5-5-2(c) the Indiana Adjudication and Court Review Act as well as authorization granting Court's jurisdiction to determine questions of law.

## II.

Plaintiffs adopt and incorporate herein by reference rhetorical paragraphs 1 through 10 of Count I as if fully set forth herein.

11. This new rule contained at 470 IAC §5-4.1, initially appeared as a proposed rule in the Indiana Register on or about April 1, 1988. After a written comment period, the rule was discussed in a public meeting conducted by the DPW staff on May 3, 1988. No member of the Executive Board of DPW (hereinafter "DPW Board") was present at that meeting.

12. On June 28, 1988, the DPW Board improperly approved the purported rule as "final". In the meeting at which the purported rule was adopted, only three out of the seven board members were present, with two having left proxies. Those three board members were not given any oral or written record or summary of the public comments that the DPW staff had received in the earlier comment period, nor were they apprised of any legal issues raised by the rule.

13. The purported "final" rule contains revisions which differed substantially from the version of the rule which was originally published as a proposed rule on or about April 1, 1988.

14. By adopting this purported final rule without a quorum, the DPW Board has failed to comply with IC 4-22-2-19, which delegates final rule adoption authority only to an "agency". According to IC 4-22-2-3, "agency" means the entity which has the authority to exercise the "executive powers" of the state government. In this case, executive power rests only with a *majority* of the entire DPW Board. Proxies do not cure this procedural deficiency.

15. By adopting this purported final rule without either attending the public hearing on the rule or receiving a written record or a summary of the public hearing, the DPW Board has failed to comply with IC 4-22-2-27, which specifies that "[t]he individual or group of individuals who will finally adopt the rule . . . shall fully consider comments received at the public hearing."

16. By adopting a purported final rule which contains a significant revision of the version published initially, the DPW has failed to comply with IC 4-22-2-29(b), which prohibits an agency from adopting a rule which "substantially differs" from the proposed rule.

17. Section 17(a) of this purported rule contains the provisions which, for several years, have governed the computation of a new capital cost reimbursement rate which, in effect, impose different standards for facilities which changed hands between July 17, 1984 and September 30, 1985. The rule does not offer any guidance as to how these different approaches are to be reconciled or why transactions which happened to occur during that particular time frame are singled out for this special treatment. Section 15(e) then sets up yet another category -- transactions that occurred or will occur after September 30, 1985 – and

imposes yet another set of standards. Again, no guidance is offered as to why this separate category is established or how the inconsistency with Section 17(a) is to be reconciled.

18. Under Section 15(c) through (e), whether a transaction is to be placed into one of these special categories depends on when a "change of provider status" occurred. That term is defined in Section 2 of the rule in a manner which is not clear but seems to suggest that a "change in provider status" occurs when the DPW "recognizes" a transaction as such. But nowhere in the rule does the DPW provide any standards or guidance as to how it will decide that very important issue.

19. Sections 15(c) through (e) also carry the clear implication that companies like plaintiffs, with transactions falling into these special categories, may be subject to a retroactive "roll-back" of rates they have received in recent years under the provisions of Section 17(a). The DPW has apparently informed certain providers or staff members of the Indiana Health Care Association (hereinafter IHCA), it will not exercise "roll back" authority, but DPW has not publicly revealed its intentions on this major issue.

20. There are several other examples in which the DPW has published only part of its intentions but has retained uncontrolled discretion to apply and interpret provisions as it wishes. This approach makes it impossible for the plaintiffs to reach rational business decisions in the light of unclear standards.

21. Regardless of how the DPW eventually decides to apply them, Sections 15(c) through (e) clearly:

> (a) provide for retroactive application constituting an unconstitutional taking or interference with plaintiffs' vested property rights without due process of law, in violation of the due process clause of the Fourteenth Amendment to the United States Constitution and Article 1, §12 of the Indiana Constitution; and

(b) create unwarranted classifications unsupported by any rational basis, in violation of the equal protection clause of the Fourteenth Amendment of the United States Constitution and Article 1, §23 of the Indiana Constitution.

22. The defendants however have been restrained from utilizing the purported "final rule" promulgated as LSA Doc. #88-33F.

23. The enabling statute for this entire rule is IC 12-1-7-17.2(b), which provides that payment for long-term care facilities of this type

> " . . . shall, under 42 U.S.C. §1396a(a)(13)(A), be determined in accordance with a prospective payment rate that is reasonable and adequate to meet the costs that are incurred by efficiently and economically operated facilities in order to provide care and services in conformity with state and federal laws, rules, regulations, and quality and safety standards, with a growth or profit factor, as determined in accordance with generally accepted accounting principles . . . "
>
> [Effective July 1, 1990, this provision is recodified as IC 12-1-7-17.6(b)]

24. This rule and previous unpromulgated policies of the defendants contain several provisions which are not authorized by that statute and, in fact, conflict directly with the express mandate of the statute. These include for example, the following sections:

> Section 2. The changed definition of "ordinary patient related costs" to "necessary" conflicts with the mandate to encourage quality care.
>
> Section 9(a)(3). The maximum allowable rate increase cap has no direct relationship to costs; it is a function only of previous rates. Further, the index used (an average of the past three years projected fifteen months in

the future) cannot possibly reflect adequate costs and expenses in the specialized long term health care field. Health care costs are rising at a rate of 10-20% per annum which this CPI index raises only 2-3% per annum.

Section 10(d). The arbitrary and capricious use of the 75th and 90th percentile as the upper limits undermine the reasonableness of cost reimbursement. This in turn causes an erosion in realized profits and will ultimately result in reasonable costs exceeding the authorized rate.

Section 16(d). The requirement to remove all of the historical cost of a traded or replaced improvement is not in accordance with generally accepted accounting principles.

25. The Plaintiffs have been advised by the defendants' staff counsel that it is the department's policy to assert the regulations in question herein as well as the prior unpromulgated policies as to all other Medicaid providers. The Plaintiffs seek to represent all Indiana Medicaid certified health care providers so that if said regulations, both promulgated and unpromulgated, are deemed invalid, they would be invalid as to all health care providers certified for Medicaid reimbursement in the State of Indiana.

26. Effective April 1, 1983, the defendants and their agents, Myers & Stauffer, have implemented policies that improperly adjust provider budgets and their respective rates. Attached hereto as Exhibit B is a description by Myers & Stauffer under date of October 5, 1983 of the rate setter's budget adjustments on cost profiles. Attached hereto as Exhibit C is the defendants' purported approval of the budget adjustment procedure under date of October 24, 1983. This procedure is in excess of defendants' statutory authority and was not properly adopted and promulgated pursuant to Indiana law and is therefore invalid

and of no effect. Furthermore the policies advanced by these rate limitations are contrary to the legislative mandate contained in IC 12-1-7-17.6(b) quoted *supra* at paragraph 24.

27. The Plaintiffs allege that the defendants have implemented policies against the class described herein which deny the Plaintiffs and the class adequate reimbursement in violation of IC 12-1-7-17.2 and that said denial results from the application by the defendants of unpromulgated rules. Said application is prohibited by Indiana law. *Blinzinger* v. *Americana Healthcare Corp.*, (Ind. App. 2 Dist. 1984), 466 N.E.2d 1371.

28. The defendants are liable to the Plaintiffs and all others similarly situated for damages measured by the difference between the Medicaid rates of reimbursement which should have been paid to the class and the amounts actually paid as a result of the defendants' illegal and improper application of unpromulgated rules and policies against the class. The Plaintiffs seek both prospective and retroactive monetary relief as a result of the defendants' actions.

29. The Plaintiffs further allege that the defendants have utilized other arbitrary and capricious limitations including, but not limited to, an annual limiter imposed pursuant to previously existing Medicaid regulations which arbitrarily limits Medicaid providers being reimbursed for extraordinary costs in contravention of IC 12-1-7-17.6 and 42 U.S.C. §1396a(a)(13)(A). Plaintiffs seek declaratory "and other relief" on behalf of themselves and the class represented thereby resulting from the department's application of said arbitrary limitations. IC 34-4-10-8.

30. Plaintiffs also have a cause of action pursuant to IC 4-21.5-2(c) for judicial review of a nonfinal agency action in that the defendants will suffer immediate and irreparable harm as a result of the actions of the defendants complained of herein. The Plaintiffs have no adequate remedy at law in that it is not economically feasible or judicially practicable for each Intervenor and affected member of the class to bring a separate administrative action for relief.

31. Plaintiffs are representatives of a class of all Medicaid certified health facility providers and seek to bring this action on behalf of themselves and all others similarly situated.

32. The Plaintiffs intend to prosecute this action as a class action pursuant to TR 23(B)(2) and (3), Indiana Rules of Procedure for all Indiana Medicaid certified health facilities that have been in operation from April 1, 1983 to the promulgation of proper regulations that comply with the state and federal statutes.

33. The Plaintiffs are adequate representatives of the above defined intervenor class because they have the same interests as all members of their class, their interests are typical of the class, and the named Plaintiffs will fairly and adequately protect the interests of the unnamed class members.

34. The defendants have acted or refused to act on grounds generally applicable to all members of the class thereby making appropriate final injunctive relief and/or corresponding declaratory relief appropriate and applicable with respect to the class as a whole.

35. There are furthermore questions of law or fact common to the members of the class which predominate over any questions affecting only individual members and this class action is superior to other available remedies for the fair and efficient adjudication of the controversy.

36. The Plaintiffs will vigorously prosecute this action and are represented by counsel experienced in representing health care providers in the State of Indiana.

37. The interests of the Plaintiffs and the class are not adequately represented in the other law suit referenced in rhetorical paragraph 22 in that plaintiffs therein failed to: (a) request equitable relief as to unpromulgated rules and policies; (b) request extension of equitable relief granted heretofore to the class; and (c) failed to request money damages to adequately compensate any of the plaintiffs for the defendants' unlawful application of

unpromulgated rules. Facilities in this State are being sold for the sole purpose of increasing rates or are in imminent danger of insolvency due to the rates being below costs.

38. That the questions of law and fact stated herein are common to the class and predominate over any questions affecting only the individual class members. A class action is superior to several hundred individual causes of action or judicial reviews and will promote a fair and efficient adjudication of this controversy.

39. The Plaintiffs have a substantial claim in the damages by reason of the illegal rate setting activity of the defendants, as do the other class members. The prosecution of numerous separate actions would create the risk of varying adjudications or would establish incompatible standards of conduct for the parties opposing the class and would result in substantial discovery costs and court time.

40. The members of the class are so numerous that joinder of each class member would be impractical. Plaintiffs believe the class to consist of approximately six hundred (600) affected parties plaintiff.

**III.**

Plaintiffs adopt and incorporate herein by reference rhetorical paragraph 1 through 40 of Counts I and II as if fully set forth herein.

41. 42 U.S.C. §1396a(a)(13)(A) (Supp. 1988), (the "Boren Amendment"), provides that a state that participates in the Medicaid Program must reimburse facilities according to rates that the

> [S]tate finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care

> and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. . . .

42. In addition, at least annually, and whenever the state Medicaid agency makes a change in its reimbursement methods or standards, the State must make certain specific "findings" regarding the state Medicaid Program's compliance with federal law. Among other things, the State must make a finding that Medicaid payment rates are in fact reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards. 42 C.F.R. §447.253(b) (1989).

43. The federal regulations implementing the Boren Amendment also require that whenever a state desires to make any change to an approved state Medicaid plan, the State must submit the proposed amendment to the Secretary ("Secretary") of the Department of Health and Human Services and obtain approval of the proposed change. See 42 U.S.C. §1396c(1982); 45 C.F.R. §201.3 and §205.5(a) (1989).

44. Whenever the State Medicaid agency wishes to amend the State Medicaid Plan, the State must submit "assurances" to the Secretary that the required findings were in fact made, and that the other requirements imposed by federal law are met. 42 C.F.R. §447.253(a) (1989).

45. Since 1983, the defendants have failed to make these required findings, in violation of the Boren Amendment and the implementing federal regulatons.

46. Since 1983, the defendants have failed to make these required assurances in violation of the Boren Amendment and the implementing federal regulations.

47. Defendants have failed to promulgate any regulation to define the objective benchmark of what constitutes an "efficiently and economically operated facility" providing care in compliance with federal and state quality and safety standards in violation of the Boren Amendment.

48. Since 1983, the defendants have failed to reimburse Plaintiffs according to rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulatons and quality and safety standards. . . . ". 42 U.S.C. §1396a(a)(13)(A) (Supp. 1988); 42 C.F.R. §447.252(a) (1989); 47 Fed. Reg. 31518 (July 10, 1982).

49. IC 12-1-7-17.6(b)(1990) incorporates the substantive payment standards under the Boren Amendment and also guarantees in addition payment of a "growth or profit factor".

50. Accordingly, the Indiana Medicaid Program violates 42 U.S.C. §1396a(13)(A), the implementing federal regulations, the Supremacy Clause of the United States Constitution and IC 12-1-7-17.6(b)(1990).

WHEREFORE, Plaintiffs, by counsel pray for relief as follows:

1. For a preliminary and permanent injunction prohibiting defendants from applying or enforcing the rule LSA #88-33 attached as Exhibit A.

2. For a preliminary and permanent injunction prohibiting defendants from applying or enforcing unpromulgated rules and policies which deny the Plaintiffs and the class adequate reimbursement in violation of IC 12-1-7-17.6(b) and 42 U.S.C. §1396a(a)(13)(A).

3. For a declaratory judgment that the rule identified as Exhibit A and the purported policies identified as Exhibit B and Exhibit C: (a) are not properly adopted and promulgated pursuant to Indiana law and are therefore invalid and of no effect;

(b) do not provide sufficient ascertainable standards and are therefore contrary to administrative due process; (c) constitute an unlawful taking or interference with Plaintiffs' and members' of the class vested property rights without due process of law, in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution and Article 1, Section 12 of the Indiana Constitution; (d) create unwarranted classifications unsupported by any rational basis, in violation of the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution and Article 1, Section 23 of the Indiana Constitution; (e) are so imprecise as to necessarily be subject to arbitrary or capricious application, in violation of the Due Process Clause of the Fourteenth Amendment of the United States Constitution and Article 1, Section 12 of the Indiana Constitution; and (f) are in excess of and are contrary to defendants' statutory authority and are therefore invalid and of no effect.

4. For a declaratory judgment that the Indiana Medicaid Program pays rates that violate IC 12-1-7-17.6(b)(1990); 42 U.S.C. §1396a(a)(13)(A) (Supp. 1988), the implementing federal regulations, and the Supremacy Clause of the United States Constitution.

5. For an award of attorneys' fees pursuant to 42 U.S.C. §1988 and TR 23(D), Indiana Rules of Procedure.

6. For damages to be measured by the difference between the Medicaid rates of reimbursement which should have been paid to the Plaintiffs and the class and the amounts actually paid as a result of the defendants' illegal and improper application of unpromulgated rules against the Plaintiffs and the class both prospectively and retroactively.

7. For damages as measured by the difference between the Medicaid rates that were in fact paid to class members from April 1, 1983, to the date of a judgment herein, and the reasonable and adequate rates of reimbursement that meet the costs

which must be incurred by efficiently and economically operated facilities, as required by IC 12-1-7-17.6(b) and 42 U.S.C. §1396a(a)(13)(A), whichever is greater.

8. For an order to the defendants to properly promulgate regulations which comply with the statutory requirements of IC 12-1-7-17.6(b) (1990) and 42 U.S.C. §1396a(a)(13)(A) (Supp. 1988) as to payment for services rendered by skilled and intermediate health care facilities, and that these new regulations be promulgated in accordance with the statutory requirements contained in IC 4-22-2.

9. All other relief just and proper in the premises.

Respectfully submitted,

STEERS, SULLIVAN,
MCNAMAR & ROGERS

By: _____
David F. McNamar

**CERTIFICATE OF SERVICE**

I hereby certify that a copy of the foregoing was served on the following counsel of record by first class U.S. mail, postage prepaid this 26th day of October, 1990:

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## APPENDIX I

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF INDIANA**
**INDIANAPOLIS DIVISION**

INDIANA HEALTH CARE ASSOCIATION, INC.; INDIANA ASSOCIATION OF HOMES FOR THE AGING, INC.; THE HILLHAVEN CORPORATION, d/b/a Hillhaven Wedgewood, THE INDIANAPOLIS JEWISH HOME, INC., d/b/a Hooverwood, LITTLE COMPANY OF MARY HEALTH FACILITY; ST. MARY'S MEDICAL CENTER OF EVANSVILLE, INC., d/b/a Regina Continuing Care Center, and SUMMIT CONVALESCENT CENTER, on behalf of themselves and all other similarly situated long-term care facility providers certified by the State of Indiana to participate in the Indiana Medicaid program,

*Plaintiffs,*

vs.

SUZANNE MAGNANT, as Administrator of the Indiana State Department of Public Welfare and a member of the Indiana State Board of Public Welfare, MARJORIE H. O'LAUGHLIN, as Treasurer, State of Indiana, THE INDIANA STATE DEPARTMENT OF PUBLIC WELFARE, and THE INDIANA STATE BOARD OF PUBLIC WELFARE,

*Defendants.*

*NO.IP 90-1573-C*

## ENTRY

This matter comes before the Court on a motion by the defendants requesting the Court to stay this action pursuant to the abstention doctrine. For the following reasons, the motion is granted.

### Background

This is an action for declaratory and injunctive relief brought pursuant to Title 42 U.S.C. § 1983 for alleged violations of federal law by Indiana's Medicaid program. The plaintiffs are long-term health care providers and two of their trade associations. They allege that the State of Indiana has failed to comply with procedural and substantive federal requirements in adopting and implementing rules governing reimbursement rates. The defendants are the Indiana DPW, the Indiana State Board of Public Welfare and state officials Suzanne Magnant and Marjorie H. O'Laughlin.

**Regulatory background**

Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* (The Medicaid Act) establishes the cooperative federal-state medical assistance program called Medicaid. Under the Medicaid program, a state which elects to participate receives federal funding which, in combination with state funds, is used to reimburse health care facilities which provide care to needy individuals.

A participating state must devise a reimbursement plan that conforms to certain federal requirements, and must submit that plan to the Secretary (Secretary) of the United States Department of Health and Human Services for approval. 42 U.S.C. § 1396a(b). After the Secretary has approved the state plan, the state must also satisfy certain continuing obligations to qualify for federal participation. For example, at least annually, and whenever the state Medicaid agency makes any change in its

reimbursement methods or standards, the state must make certain findings that Medicaid payment rates are reasonable and adequate. 42 C.F.R. § 447.253(b) (1989). Also, whenever the state Medicaid agency wishes to amend the state plan, the state must submit "assurances" to the Secretary that the required findings were in fact made, and that the other requirements imposed by federal law are met. 42 C.F.R. § 447.253(a) (1989).

Title 42 U.S.C. § 1396 sets out the federal requirements for reimbursement of health care providers under state plans. As amended in 1980, section 1396(a)(13)(A) (the Boren Amendment) provides that the state plans ensure that facilities will be paid rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards."

Indiana has enacted an implementing provision nearly identical to the Boren Amendment:

> Payment of skilled nursing facility and intermediate facility services shall under 42 U.S.C. 1396a(13)(A) be determined in accordance with a prospective payment rate that is reasonable and adequate to meet the costs that are incurred by efficiently and economically operated facilities in order to provide care and services in conformity with state and federal laws, rules, regulations, and quality of safety standards, with a growth or profit factor determined in accordance with generally accepted accounting principles and in accordance with rules adopted by the department.

Ind. Code § 12-1-7-17.2(b) (1989) (changed by amendment in 1990 to § 12-1-7-17.6(b)).

In the instant case, the plaintiffs assert that Indiana's Medicaid program was adopted and has been implemented in violation of the applicable federal procedural requirements, and that for a period of years, Indiana has paid, and continues to pay,

long-term care facilities at rates that are less than the reasonable costs associated with the efficient and economical delivery of services to Medicaid beneficiaries. In their fourteen-count complaint, they assert, *inter alia*, that the State failed to provide the required "findings and assurances" with regard to amendments to state plans made in 1983 and 1988. They further assert that in the years 1987 through 1989 no such findings could have been made, since the reimbursement rates used were not reasonable and adequate. They challenge a number of "limiters" on rates, which are part of the State's reimbursement methodology, with particular emphasis on what plaintiffs describe as the "maximum annual limiter." This limiter is found at 470 Ind. Admin. Code § 5-4.1-9(c)(3), which provides, in relevant part:

> The maximum allowable annual rate increase shall not be greater than the average rate of change, expressed as a decimal, of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator . . . The maximum rate allowed by the annual rate increase limitation shall be equal to the rate in effect immediately prior to the rate effective date of the annual rate review . . . plus the maximum allowable annual rate increase applicable at the rate effective date of the annual rate review.

Pursuant to this regulation, a nursing home is prevented from having a rate in one year that is greater than its prior year's rate as adjusted for inflation as measured by the Gross National Product Implicit Price Deflator.

Three state court cases also challenge Indiana's reimbursement methodology and in particular the use of this limiter. The defendants request that the Court stay this action in deference to parallel state court proceedings.

**Discussion**

The defendants ask the Court to stay this case under the doctrine of *Colorado River Water Conservation District* v. *United States*, 424 U.S. 800, 96 S.Ct. 1236, 47 L.Ed.2d 483 (1976) and its progeny.

The "exceptional circumstances test" established by the Supreme Court in *Colorado River*, 424 U.S. at 817-21, 96 S.Ct. at 1246-48, 47 L.Ed.2d at 498-500, permits a district court to stay an action where there is an ongoing parallel action in state court. *LaDuke* v. *Burlington Northern R. Co.*, 879 F.2d 1556, 1558 (7th Cir. 1989). Deference to the state courts is supported in such cases by considerations of wise judicial administration, conservation of judicial resources, and comprehensive disposition of litigation. *Colorado River*, 424 U.S. at 817, 96 S.Ct. 1246, 47 L.Ed. 2d at 498. However, because the Courts have a "virtually unflagging obligation . . . to exercise the jurisdiction given them," *id.*, the mere fact that an action is pending in state court ordinarily is no bar to parallel federal proceedings. *LaDuke*, 879 F.2d at 1558 (quoting *Colorado River*, 424 U.S. at 817). The Seventh Circuit has observed that "a federal court cannot lightly abjure its responsibility to assert jurisdiction." *Lumen Constr., Inc.* v. *Brant Constr. Co.*, 780 F.2d 691, 694 (7th Cir. 1985). In considering a motion to abstain under the *Colorado River* doctrine, a district court must first determine whether the state proceedings are parallel, and then consider whether abstention is appropriate under a multi-factor balancing test.

**Parallelism**

The threshold inquiry before proceeding to the balancing factors under *Colorado River*, is whether the concurrent state and federal action are actually parallel. *LaDuke*, 879 F.2d at 1559. *See also, Day* v. *Union Mines Inc.*, 862 F.2d 652, 655 (7th Cir. 1988); *Interstate Material Corp.* v. *City of Chicago*, 847 F.2d 1285, 1287 (7th Cir. 1988). Cases are parallel if " 'substantially the same parties are contemporaneously litigating substantially the same

issues in another forum.' " *Id.* (quoting *Calvert Fire Ins. Co.* v. *American Mut. Reinsurance Co.*, 600 F.2d 1228, 1229 n.1 (7th Cir. 1979). In making their determination, courts "look not for formal symmetry between the two actions, but for a substantial likelihood that the state litigation will dispose of all claims presented in the federal case." *Lumen Constr.*, 780 F.2d at 695.

Plaintiffs brought this action in the Southern District of Indiana on July 10, 1990, seeking injunctive and declaratory relief on grounds that Indiana's Medicaid program violates federal procedural and substantive requirements. The plaintiffs here are two trade associations and five nursing homes suing on behalf of a class of long-term care facilities in Indiana. According to the complaint, Indiana Health Care Association (IHCA) has a membership of over 460 long-term care facilities, which is approximately 80% of the long-term facilities in Indiana. Indiana Association of Homes for the Aging, Inc. (IAHA) is an association of 135 Indiana health care providers, including 107 long-term facilities, which facilities comprise 28% of the long-term care providers in Indiana.

The defendants are the Indiana Department of Welfare (DPW), which is the state agency responsible for administering the Medicaid reimbursement program in Indiana; the Indiana State Board of Public Welfare (the Board), which is responsible for the adoption of rules governing DPW; Suzanne Magnant, the Administrator of DPW and Secretary of the Board; and Marjorie H. O'Laughlin, the Treasurer of the State of Indiana, who is responsible for effecting payment to long-term care facilities receiving Medicaid funds.

The defendants have identified three cases now pending in Indiana state courts which they argue constitute proceedings parallel to the federal action. After reviewing the parties and issues involved in each case, the Court agrees with the defendants that two of them are parallel.

The first of the three state cases is *Indiana Health Care Ass'n, Inc.* v. *Magnant*, No. 49D029007-CP1094 (Marion County)

(the Marion County case). This case, filed one week after its federal counterpart on July 18, 1990, is virtually identical to the case before this Court. The exact same plaintiffs and defendants are named in the Marion County case. The fourteen-count state complaint alleges the same violations as does the federal complaint, and requests the same relief, except that the state complaint seeks compensatory damages in excess of $125,000,000, representing the difference between Medicaid costs incurred and Medicaid payments received by long-term facilities since 1983. The plaintiffs do not argue that the Marion County case is dissimilar from the case before this Court. Rather, they note that they have not served the defendant DPW in the state case, and argue that the state court complaint was filed "solely as a protective measure to toll any statute of limitations that might apply to a damage claim and to otherwise preserve fully (IHCA's) rights to an adjudication on the merits in the event this federal case is terminated without full relief."

The Marion County case is clearly parallel to the case at hand, under the *Colorado River* language. That is, the parties and issues are "substantially parallel." In their response brief, the plaintiffs argue that the filing of such a protectionary action is legitimate, and does not compel abstention. While it may be true that the state filing does not automatically compel abstention, the Marion County case at least indicates a threshold finding that such case is a parallel proceeding. Under the multi-factor balancing test of *Colorado River* and its Seventh Circuit progeny, however, the existence of the Marion County case alone would not necessarily compel abstention, since the Marion County case was later filed and has made no progress as a result of plaintiffs' decision not to serve DPW at this time. The most compelling reason for this Court to stay the instant case is the existence of the "Tioga Pines" case.

The second case pending in Indiana state court to which defendants refer is *Tioga Pines Living Center, Inc.* v. *Indiana State Board of Public Welfare*, No. 30C01-9002-CP-00125 (originally filed in Marion County and subsequently transferred to Hancock

County) (the Tioga Pines case). The case was originally filed on January 24, 1990. Original plaintiffs were four Indiana nursing homes seeking to represent as a class all Indiana Medicaid-certified nursing homes. On October 29, one hundred fifty-one Indiana nursing homes were added on a motion to intervene. The defendants are the Indiana DPW, the Indiana State Board of Public Welfare, and Suzanne Magnant. We believe that the absence of the trade associations as plaintiffs and the state treasurer as a defendant does not render the Tioga Pines case non-parallel to the present action. Rather, the nursing homes are the real parties in interest in either action, and the DPW and State Board of Public Welfare are clearly the principal defendants in either.

More importantly, the issues involved in Tioga Pines are substantially parallel to those involved in the instant case. When it was originally filed, the Tioga Pines case contained state claims which may be described as follows: 1) the 1988 amendments to the state reimbursement rules were promulgated in violation of state statutory rulemaking procedures and are invalid; 2) certain rules relating to changes of ownership of health care providers are imprecise and thereby have been applied arbitrarily by DPW; 3) DPW has used unpromulgated "rules" to set facility rates; 4) DPW's use of the 1988 amendments and unpromulgated rules deny long-term facilities adequate reimbursement under Ind. Code § 12-1-7-17.2(b); and 5) certain rules including the use of the "maximum annual limiter," are in excess of DPW's statutory authority and conflict with Ind. Code § 12-1-7-17.2(b).

At the time of original filing the Tioga Pines complaint asserted three federal law violations: 1) DPW's change of ownership reimbursement rules are arbitrary classifications of ownership in violation of the Equal Protection guarantees under the Fourteenth Amendment of the United States Constitution; 2) the retroactive application of such ownership reimbursement rules results in an unconstitutional taking also in violation of the

Fourteenth Amendment; and 3) certain limiting rules including the "annual limiter" are arbitrary and capricious and violate the Boren Amendment, 42 U.S.C. §1396(a)(13)(A).

In arguing the lack of parallelism between *Tioga Pines* and the instant case, the plaintiffs emphasized that the *Tioga Pines* case contained only three narrow federal challenges. At that time plaintiffs did not allege defendants' failure to make findings and assurances in compliance with federal regulations, nor did they allege substantive violations of the Boren Amendment. On October 31, 1990, the *Tioga Pines* plaintiffs amended their complaint in order to add allegations of failure to comply with precisely the same federal procedural and substantive requirements which the plaintiffs in this case have identified. Part III of the *Tioga Pines* complaint replicates many of the rhetorical paragraphs contained in the instant complaint, to assert procedural and substantive violations of federal law. In the newly added Part III, *Tioga Pines* plaintiffs assert that the defendants failed to make the findings and assurances required pursuant to 42 C.F.R. §§ 447.253(a) and (b). They also assert that since 1983, the defendants have failed to reimburse plaintiffs according to rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards" in contravention of 42 U.S.C. § 1396(a)(13)(A) (the Boren Amendment).

As regards remedies, the *Tioga Pines* plaintiffs seek declaratory and injunctive relief, as well as damages as measured by the difference between the Medicaid rates of reimbursement which should have been paid to the facilities and the amounts actually paid.

In sum then, the *Tioga Pines* complaint now alleges the same basic procedural and substantive violations of federal law as are here alleged, though the state complaint does so in considerably less detail, it makes similar allegations as to inadequate

reimbursement, and it includes specific allegations regarding invalidity of the "maximum annual limiter". Finally, the plaintiffs in *Tioga Pines* seek much of the same injunctive and declaratory relief as that sought in the federal action, as well as damages.

The complaint filed in this Court describes in far greater detail the particular ways in which the State Plan allegedly violates federal law. The allegations of procedural violations are at Section V, Part D of the complaint, and the allegations of substantive violations at Section V, Part E. In Part D plaintiffs allege that DPW's 1983 submission to the Secretary did not make the required assurances that reimbursement rates were reasonable and adequate, and also that the required findings have not been made since 1983. Further, they allege that rates were not reasonable or adequate during the years 1987 through 1989, and therefore that DPW did not and could not have made such findings for those years. They also challenge the procedural validity of the 1988 amendments.

In Part E the plaintiffs charge that DPW has failed to comply with federal substantive standards. Here, the plaintiffs challenge three specific components of the State Plan's payment methodology. They first allege that the Indiana Medicaid Program's "Capital Return Factor," which DPW uses to reimburse providers for costs of land, facilities and equipment, results in rates that are substantially below the capital costs actually incurred by efficiently and economically operated facilities. Next, they challenge sufficiency of reimbursement rates related to staffing. Finally, they challenge the "maximum annual limiter" on several grounds.

Plaintiffs' Prayer For Relief in the instant case is quite detailed in contrast to that in the *Tioga Pines* complaint. Here, plaintiffs request the Court to make a number of detailed declarations regarding the manner in which the State Plan allegedly violates federal law. While the *Tioga Pines* complaint requests

invalidation of certain rules promulgated by the DPW, the instant complaint seeks invalidation of the State's reimbursement methodology as a whole, by detailing the various areas in which the methodology allegedly fails.

As noted above, in deciding whether cases are parallel, it is not necessary that the exact same issues be present. The Seventh Circuit has emphasized that the district court must decide whether "substantially the same issue" has been raised in the state court, such that the district court "may reasonably assume that the federal issue would be decided in the full course of the state litigation." *Day*, 862 F.2d at 656, 657.

Comparing the instant case to *Tioga Pines*, it is clear that the state case encompasses the broad issue of whether the DPW and the Board have violated federal procedural requirements for findings and assurances since 1983, and whether those defendants have substantively violated the Boren Amendment since 1983 by failing to reimburse long-term care facilities according to rates that are reasonable and adequate. What the state complaint lacks is the detailed challenge to various components of the State Plan which is apparent in the federal complaint. However, a resolution in state court of the broad questions of federal procedural and substantive violations would effect the reimbursement methodology in Indiana as a system.

Moreover, the "maximum annual limiter" upon which the federal plaintiffs have focused is specifically challenged in the *Tioga Pines* litigation and has been the subject of a preliminary injunction entered by the state court in that case on May 29, 1990. The trial court enjoined the use of the limiter, stating that "it does not have a direct or any other relationship to incurred health care costs to restrict reimbursement of the reasonable costs now being incurred by these facilities" and that in contravention of Ind. Code § 12-1-7-17.2(b), "[i]t is a function only of previous rates and is a budget driven limiter."

We believe that resolution of the *Tioga Pines* federal challenges will substantially resolve core issues involved in the complaint here at issue. Because of the level of similarity of parties and issue, we find that the *Tioga Pines* case is parallel to this action.

Finally, the third case which defendants identify as having overlapping concerns is *Community Care Centers, Inc. v. Indiana State Board of Public Welfare*, No. 05C01-8808-CP-085 (Blackford County) (Community Care). The plaintiffs are Community Care Centers (a corporation operating sixteen long-term care facilities in Indiana) and IHCA; the defendants are DPW, the Board and Suzanne Magnant. Although the members of the possible class in the federal action are technically not represented in the state action, the relief requested will benefit them. *See Canaday v. Koch*, 608 F. Supp. 1460, 1474 (S.D.N.Y. 1985).

In the *Community Care* case, filed in July, 1988, the plaintiffs challenge the promulgation of the 1988 amendments on procedural grounds, as in *Tioga Pines*. They also challenge the application of the "maximum annual limiter," 470 Ind. Admin. Code § 5-4.1-9(c)(3) as a violation of Ind. Code § 12-1-7-17.2(b). On July 29, 1988, the trial court restrained the DPW from utilizing the allegedly defectively promulgated rules to calculate reimbursement rates. On June 5, 1990, the state trial court granted Community Care Centers a temporary restraining order disallowing the use of the Gross National Product Implicit Price Deflator as the sole method of determining a reasonable rate of reimbursement. The *Community Care* case did not involve allegations that defendants violated federal procedural requirements (findings and assurances) or substantive violations of the Boren Amendment.

This Court finds that the *Community Care* case alone would not constitute proceedings parallel to the instant case. Although it does involve some of the same core issues, i.e., the validity of the "maximum annual limiter," it does not involve the issues of federal law raised in the instant case, that is, the challenges based on federal procedural violations and substantive violations of the

Boren Amendment. We believe that the federal plaintiffs' charges that the State failed to make "findings and assurances" is important, and that the lack of any allegations of federal procedural violations renders *Community Care* sufficiently different from the instant case that we cannot find them to be parallel. However, even though the *Community Care* case alone is not parallel, it has already progressed substantially on the issue of the maximum annual limiter. In conjunction with the *Tioga Pines* case, we think this progress relevant.

In sum, the Court finds that the Marion County case and the *Tioga Pines* case present substantially the same parties and issues as does the instant case. Accordingly, we proceed to the second stage of the *Colorado River* analysis.

**Whether the Colorado River factor analysis supports a stay**

The second part of a district court's determination of whether to stay an action under *Colorado River* involves a multi-factor balancing test. Under this test, the district court must "consider a number of factors that might justify a decision to refrain from exercising jurisdiction over an action." *LaDuke v. Burlington Northern R. Co.*, 879 F.2d at 1559. The Seventh Circuit has articulated ten factors to be considered:

> 1) whether the state has assumed jurisdiction over property; 2) the inconvenience of the federal forum; 3) the desirability of avoiding piecemeal litigation; 4) the order in which jurisdiction was obtained by the concurrent forums; 5) the source of governing law, state or federal; 6) the adequacy of state-court action to protect the federal plaintiff's rights; 7) the relative progress of state and federal proceedings; 8) the presence or absence of concurrent jurisdiction; 9) the availability of removal; and 10) the vexatious or contrived nature of the federal claim.

*Id.* Of the factors listed, "[n]o one factor is necessarily determinative." *Colorado River*, 424 U.S. at 818, 103 S.Ct. at 1237, 47 L.Ed.2d at 499; rather, "[t]he weight to be given any factor may

vary greatly from case to case, depending on the particular setting of the case." *Moses H. Cone Memorial Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 16, 103 S.Ct. 927, 937, 74 L.Ed.2d 765, 780 (1983). Proceeding through the multi-factor analysis we bear in mind that the balance is "heavily weighted in favor of the exercise of jurisdiction." *Id.*

The first two factors are not applicable to our analysis since there is no property involved and since all of the parties are citizens of Indiana.

Two of the above factors are especially relevant in this case and weigh heavily in favor of abstention: the desirability of avoiding piecemeal litigation and the progress of state proceedings.

"Piecemeal litigation occurs when different tribunals consider the same issue, thereby duplicating efforts and possibly reaching different results. . . . " *Day* v. *Union Mines, Inc.*, 862 F.2d at 659 (quoting *American Int'l Underwriters, (Philippines), Inc.* v. *Continental Ins. Co.*, 843 F.2d 1253, 1259 (9th Cir. 1988)). Courts seek to avoid the " 'grand waste of efforts by both the courts and parties in litigating the same issues regarding the same [policies] in two forums at once.' " *Interstate Material Corp.* v. *City of Chicago*, 847 F.2d at 1289 (quoting *Microsoftware Computer Systems* v. *Ontel Corp.*, 686 F.2d 531 (7th Cir. 1982)). In this way the courts may serve the *Colorado River* doctrine's goal of promoting "wise judicial administration, giving regard to conservation of judicial resources and comprehensive disposition of litigation." *Colorado River*, 424 U.S. at 817, 96 S.Ct. at 1246, 47 L.Ed.2d at 498.

In this case, there is a substantial likelihood that exercise of this Court's jurisdiction would result in piecemeal litigation of the issues and sub-issues involved in a challenge to the state Medicaid agency's reimbursement methodology. Each of the state cases challenges portions of the reimbursement scheme, and the *Tioga Pines* case now includes a broad challenge under federal procedural and substantive requirements. The state and federal regulations involved are detailed and complex. Their

application with regard to the central substantive issue in all cases, the adequacy of the reimbursement system, should not be subject to piecemeal litigation in the federal and state courts. Moreover, only the state courts can resolve both the damage claims and the claims that the reimbursement scheme violates state law.

As regards the relative progress of the cases in state court, the *Community Care* and *Tioga Pines* cases were filed well before the filing of this case in July of 1990, and have made considerable progress. As noted above, in each of those two cases the state trial court has granted preliminary injunctive relief aimed at the maximum allowable rate and the procedural inadequacies of the 1988 amendments, both of which are issues of major concern in the case at hand. In *Tioga Pines*, the state trial court has ordered defendants to pay $4 million per month into an escrow account. This order is now pending appeal to the Indiana Court of Appeals.

In contrast to the more important issue in this case of how far the state cases have progressed, the order in which the courts obtained jurisdiction is less of a compelling factor than defendants argue. While the first two cases were filed between six months and two years before the filing of the federal case, the Marion County Case was filed just afterward. Thus, we are not here presented with the situation where a plaintiff has selected state court as a forum for a federal claim, then proceeded to file the identical claim in federal court. *See*, *LaDuke*, 879 F.2d at 1557, 1561 (plaintiff filed FELA claim in state, then federal court). We believe that the interests of the plaintiffs in this case are adequately represented in *Tioga Pines*; the overlap of issues in that case and the progress already made on certain of those issues militates strongly in favor of abstention. As noted above, the present plaintiffs are represented, we think adequately, by the class representation in *Tioga Pines*.

The next factor to consider is the source of governing law. Where federal courts have exclusive jurisdiction, such as in certain federal securities laws claims, abstention is appropriate in

only rare circumstances if at all. *See*, *Medema* v. *Medema Builders, Inc.*, 854 F.2d 210, 212 (7th Cir. 1988). Here, the plaintiffs' broad challenges under the Boren Amendment clearly do arise under federal statutes and regulations, but we do not agree with the plaintiffs' implication that this circumstance mandates the exercise of this Court's jurisdiction. While the source of governing laws is certainly a factor to consider, we are not persuaded that plaintiffs' federal claims cannot be fairly adjudicated in the state courts. " 'State courts, as much as federal courts, have a solemn obligation to follow federal law.' We decline to presume that the Indiana courts, which have concurrent jurisdiction . . . , will not discharge this obligation faithfully." *Lumen Constr., Inc.* v. *Brant Constr. Co.*, 780 F.2d at 697 (quoting *Arizona* v. *San Carlos Apache Tribe*, 463 U.S. 545, 571, 103 S.Ct. 3201, 3216, 77 L.Ed.2d 837, 859 (1983)). The state and federal courts have concurrent jurisdiction over the federal claims; we believe that the claims here at issue can be appropriately resolved in the state courts.

The final factor defendants have raised is the vexatiousness or the contrived nature of the federal claim. We disagree with the defendants' view of this case as vexatious. The case was filed by different plaintiffs, with different counsel, asserting federal claims not already a part of the *Tioga Pines* case. We are more concerned here with the defendants' argument that they will be forced to defend multiple complex and duplicative cases, which argument has been considerably strengthened by the addition of the Boren Amendment claims to the *Tioga Pines* case. As noted above, we believe that the exercise of various claims would lead to piecemeal litigation, and we believe that judicial resources can and should be preserved by granting defendants' motion for abstention.

**Conclusion**

The Court finds that this case parallels proceedings which are already ongoing in Indiana state courts. Moreover, the exercise of this Court's jurisdiction would result in piecemeal litigation and a waste of judicial resources. For these reasons, under the *Colorado River* doctrine, this Court defers to the state courts. The Court having decided to grant defendants' motion for abstention, the proper disposition of this case under Seventh Circuit precedent is to stay the proceedings in this Court. *Lumen Constr.*, 780 F.2d at 698. Accordingly, the Court's order to stay this action accompanies this entry.

Dated this 9th day of January, 1991.

S. Hugh Dillin, Judge

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## APPENDIX J

## IN THE SUPREME COURT OF INDIANA
## CAUSE NO. 30S01-9208-CV-00621

INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, SUZANNE MAGNANT, in her capacity as ADMINISTRATOR OF INDIANA DEPARTMENT OF PUBLIC WELFARE,

*Appellants, (Defendants Below),*

vs.

TIOGA PINES LIVING CENTER, INC., COMMUNICARE OF INDIANA, INC. d/b/a AMERICAN VILLAGE RETIREMENT CENTER, INC., MEADOW HEIGHTS NURSING CENTER, INC. d/b/a LINCOLN HILLS OF NEW ALBANY,

*Appellees, (Plaintiffs Below).*

Court of Appeals
No. 30A01-9201-CV-008

Appeal from the Circuit Court of Hancock County

Cause No.
30C01-9002-CP-00125

The Honorable
Ronald L. Gottschalk

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INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, SUZANNE MAGNANT, in her capacity as ADMINISTRATOR OF INDIANA DEPARTMENT OF PUBLIC WELFARE,

*Appellants, (Defendants Below),*

vs.

COMMUNITY CARE CENTERS, INC., and the INDIANA HEALTH CARE ASSOCIATION

*Appellee, (Plaintiff Below),*

Court of Appeals
No. 30A01-9201-CV-008
(formerly 05A02-9204-CV-153)

Appeal from the Circuit Court of Blackford County

Cause No.
05C-01-8808-CP-085

The Honorable
Bruce C. Bade

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## BRIEF OF APPELLANTS

## JURISDICTION OF THE SUPREME COURT

The basis for jurisdiction of this Court is Appellate Rule 4(A)(10). The Court granted transfer under App.R.4(A)(10) on August 13, 1992.

## STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

I. *TIOGA PINES*

1. Whether the trial court lacked jurisdiction to award damages for plaintiffs' claims.

2. Whether the trial court erred in finding that Medicaid rates were inadequate in violation of federal and state Medicaid law.

a. Whether the trial court erred in failing to apply a deferential standard of review.

b. Whether the trial court erred in finding that rates were inadequate where plaintiffs submitted no evidence of costs incurred by efficiently and economically operated providers.

c. Whether the trial court erred in finding that rates were inadequate based on evidence pertaining to two components of the Medicaid reimbursement scheme, the maximum annual limiter and the staffing limiter.

d. Whether the trial court erred in ignoring unrebutted evidence of widespread inefficiency in the nursing home industry and ignoring other evidence showing that Medicaid rates were adequate.

3. Whether the trial court erred in invalidating a part of the Medicaid reimbursement scheme known as the "tests of reasonableness."

a. Whether the trial court erred in holding that the details of the tests of reasonableness should have been promulgated as a rule in 1983.

b. Whether the trial court erred in holding that the details of the tests of reasonableness were not properly promulgated as a rule in 1988.

c. Whether plaintiffs' tests of reasonableness claim is barred by Laches.

d. Whether the trial court erred in awarding damages based on the alleged failure to promulgate the details of the tests of reasonableness.

4. Whether the trial court erred in finding that the State had failed to make annual "findings" about adequacy of rates, pursuant to a federal Medicaid regulation.

a. Whether the trial court erred in applying a de novo standard of review in determining whether the State made adequate "findings."

b. Whether the trial court erred in concluding that the State had not made adequate "findings" where plaintiffs presented no evidence that findings were inadequate and defendants presented unrebutted evidence that findings were made.

5. Whether the trial court adopted an improper method for the measurement of alleged damages, which fails to consider the plaintiffs' costs, efficiency and economy of operations, which erroneously puts the burden of proof on defendants, which erroneously required defendants to calculate the alleged damages, and which would result in windfall recoveries far in excess of statutory requirements.

6. Whether the trial court erred in failing to decertify the class when it became clear that the determination of alleged damages will require an individualized proceeding for each nursing home.

7. Whether the trial court erred in failing to make special findings under Trial Rule 32(A)(2).

8. Whether the trial court erred in its rulings relating to attorneys' fees.

a. Whether the trial court erred in awarding fees under 42 U.S.C. § 1988 when plaintiffs were not granted any relief permissible under 42 U.S.C. § 1983.

b. Whether the fee award under 42 U.S.C. § 1988 improperly included time spent litigating issues that did not arise under 42 U.S.C. § 1983.

c. Whether the trial court erred by not excluding certain nonreimbursable amounts in its award of attorneys' fees to intervenors.

d. Whether the award to class counsel of 25 percent of any recovery by the class shocks the conscience or is otherwise improper under T.R. 23(D).

## APPENDIX J

## IN THE SUPREME COURT OF INDIANA
## CAUSE NO. 30S01-9208-CV-00621

INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, SUZANNE MAGNANT, in her capacity as ADMINISTRATOR OF INDIANA DEPARTMENT OF PUBLIC WELFARE,
*Appellants, (Defendants Below),*

vs.

TIOGA PINES LIVING CENTER, INC., COMMUNICARE OF INDIANA, INC. d/b/a AMERICAN VILLAGE RETIREMENT CENTER, INC., MEADOW HEIGHTS NURSING CENTER, INC. d/b/a LINCOLN HILLS OF NEW ALBANY,
*Appellees, (Plaintiffs Below).*

Court of Appeals
No. 30A01-9201-CV-008

Appeal from the Circuit
Court of Hancock County

Cause No.
30C01-9002-CP-00125

The Honorable
Ronald L. Gottschalk

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INDIANA STATE BOARD OF PUBLIC WELFARE, INDIANA DEPARTMENT OF PUBLIC WELFARE, SUZANNE MAGNANT, in her capacity as ADMINISTRATOR OF INDIANA DEPARTMENT OF PUBLIC WELFARE,
*Appellants, (Defendants Below),*

vs.

COMMUNITY CARE CENTERS, INC., AND THE INDIANA HEALTH CARE ASSOCIATION,
*Appellees, (Plaintiffs Below).*

Court of Appeals
No. 30A01-9201-CV-008
(formerly 05A02-9204-CV-153)
Appeal from the Circuit
Court of Blackford County

Cause No.
05C-01-8808-CP-085

The Honorable
Bruce C. Bade

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## STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

I. Whether the trial court in ***Tioga Pines*** was correct in issuing a general judgment and not issuing special findings under Trial Rule 52(A)(2).

II. Whether the nursing homes had causes of action for monetary relief relating to the claims that Medicaid rates violate the Boren Amendment and its Indiana counterpart.

III. Whether the trial court erred in ruling that the nursing homes' claims for declaratory and injunctive relief were moot.

IV. Whether the trial court was correct in concluding that the state had not made findings as required under the Boren Amendment.

V. Whether the trial court was correct in concluding that the State paid Medicaid rates that violate the Boren Amendment and its Indiana counterpart.

VI. Whether the trial court was correct in concluding that the "tests of reasonableness" were invalid under state law and without legal effect.

VII. Whether the trial court was correct in ordering the State to recalculate Medicaid rates without applying the maximum annual rate increase limitation and the tests of reasonableness, and using only the remaining ratesetting criteria.

VIII. Whether the trial court was correct that the case is appropriate for class action determination of the retrospective monetary relief to be paid to each nursing home.

IX. Whether the trial court erred in barring monetary relief for the period prior to January 24, 1988, by applying a two-year (rather than ten-year) statute of limitations, and not utilizing the continuing violation doctrine to determine when the statute of limitations began to run.

X. Whether the trial court erred in awarding attorney's fees to plaintiffs' counsel under T.R. 23(D) from that portion of the

common fund that relates to the claims of those class members whose interests were represented actively by their own retained counsel.

XI. Whether the trial court erred in awarding fees to plaintiffs' counsel under T.R. 23(D) based upon a percentage of the common fund, rather than based upon the "lodestar" method.

XII. Whether the trial court erred in awarding a fee to plaintiffs' counsel from the common fund, where a reasonable fee awarded under 42 U.S.C. §1988 is sufficient to compensate plaintiffs' counsel fully for the work they performed.

XIII. Whether the trial court erred in failing to award Paul R. Black, one of intervenors' counsel, reasonable attorney's fees and expenses under T.R. 23(D).

XIV. Whether the trial court erred and abused its discretion in awarding plaintiffs' counsel a fee under T.R. 23(D) equaling one quarter of the monetary relief awarded in this case, or approximately $30 million or more.

XV. Whether the trial court erred and abused its discretion in setting the amount of the fee award to intervenors under 42 U.S.C. §1988 by cutting the lodestar amount by one-half and the expenses by one-fourth.